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A Performance Review

California's Child Welfare System

Prepared By:
Performance Review Unit
California Department Of Finance

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PREFACE

This review of California's child welfare system was performed by the Department of Finance's Performance Review Unit at the request of the Department's management. Recognizing the escalating number of children entering the system, in particular, out-of-home (foster) care and the growing financial burden on the State and county governments, policy-makers have questioned the effectiveness of the State's child welfare system in safeguarding abused and neglected children so that they can experience a healthy and nurturing childhood. Our review was initiated in the hope that information was available at the State or local level, or through nationwide research studies, that could be brought to bear on the issue of effectiveness.

This report reflects both our review of existing research studies and other literature addressing the effectiveness of California's child welfare services and similar services nationwide and our discussions with several child welfare researchers and child welfare practitioners, including the staff and management of the California Department of Social Services and the staff and management of fifteen county children services agencies. The report also contains data comparing California's child welfare system with the child welfare systems in other states.

Finally, while this report provides policy-makers with insight about the effectiveness of the State's child welfare system, it also contains recommendations and suggested action for policy-makers to consider as they debate child welfare reform.

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PROGRAM EFFECTIVENESS

Since 1980, the number of reports of child maltreatment and the number of children in foster care in California have risen dramatically. Moreover, in relation to its child population, California has one of the highest totals of reports in the nation and one of the largest totals of children in foster care. This has led some policy-makers to ask whether California's child welfare system is effectively protecting children.

In this evaluation of California's child welfare system, we attempted, without success, to answer that question. Briefly stated, little information is currently available to make a reasonable assessment about California's system. While we read and heard about information purporting to assess the system's effectiveness, we found little empirical evidence that could be used to make a reliable statement about the effectiveness of child welfare programs in California or elsewhere. Instead, most of the existing information about the State's system is either process-related (i.e., assessing or describing the types of services delivered and the time frames in which they are delivered) or information describing the child welfare population. Also, we heard considerable anecdotal information about child welfare programs, some of it attesting to effectiveness. However, very little exists about the outcomes of the services. And because it was not possible to assess the effectiveness of specific child welfare programs, we were unable to conclude anything about the cost effectiveness of those programs.

We also compared California's and other large states' performance on key child welfare indicators. We found that California ranks significantly higher than the national average for the number of substantiated or indicated reports of abuse and neglect (18.3 per 1,000 children in the population compared to 14.8 for the national average, a difference of nearly 24 percent). We also found that California places 56 percent more children in out-of-home care than the U.S. average (10.9 per 1,000 children in the State's population compared to 7.0 per 1,000 children in the U.S. population). However, we learned that national comparisons are of little value in establishing the effectiveness of any state's system. Because of the lack of uniformity with respect to definitions, methods and data collection systems, the data collected by one state often does not correspond to data from another, despite the use of common terminology. Every state uses its own definitions of child abuse and neglect and establishes its own criteria for substantiating child maltreatment. Some states count only

severe cases of abuse and neglect when reporting child maltreatment totals. Some states exclude cases of emotional abuse and medical neglect, and at least one state has excluded general neglect from its child maltreatment totals. Other states may include these cases but not consider lack of supervision sufficient to document a case of neglect. Because of these differences, even the Child Welfare League of America cautions the readers of its annual report on child maltreatment against interpreting the relative number of reports of child maltreatment, even those that are substantiated or indicated, as a reflection of a state's effectiveness in protecting children.

During our interviews with the staff of the Department of Social Services and the staff of 15 county children services agencies, we also learned of program differences among California counties which makes valid comparisons among the counties very difficult. Despite the existence of a uniform statewide emergency protocol, counties have different criteria for determining whether to investigate a report of abuse or neglect, and, for cases they investigate, for documenting that abuse or neglect in fact occurred. This, of course, makes comparisons of substantiated cases of child maltreatment among counties almost meaningless. And comparisons of counties on other measures of effectiveness are equally problematic. A county's policy regarding the use of kin as foster parents, for example, not only affects the stability of the family relationship for that county's foster children, but also affects the amount of time the county's foster children spend in out-of-home care and the number of foster children who eventually are adopted. All of these are important indicators of the effectiveness of the program, yet they sometimes are in conflict. Evidence of effectiveness in one of the measures may give the appearance of ineffectiveness in one or more of the others.

We also interviewed several child welfare experts throughout California and the rest of the United States to determine whether there is a consensus of opinion regarding appropriate outcome measures for child welfare programs. Although the experts seemed to agree that the best outcome measures are broad-based ones, such as child safety and child and family well-being, we found that few agencies were attempting to measure their performance in these or other areas. In many cases, these outcomes are difficult to measure and require the cooperation of agencies other than children services agencies to achieve. Even for outcomes considered to be within the purview of children services agencies and the juvenile court system, we found little consensus on measurable outcomes for which the children services agencies believed they should or could be held accountable. We also found little agreement on specific outcome indicators that should be used to measure achievement of an outcome and, except for data that some counties are collecting to measure the performance of selected county projects, little information is currently being collected on a statewide basis that would allow policy-makers to measure program effectiveness.

Perhaps because of this lack of agreement on specific outcome indicators to use in measuring accountability, California's officials have not instituted efforts to measure program effectiveness. We believe this is a shortcoming that should be corrected. Therefore, *we*

recommend that the Department of Social Services and the County Welfare Director's Association (CWDA) immediately commence efforts to formally adopt outcomes for the child welfare system. Further, we recommend the department and CWDA identify outcome indicators, supported by data elements that will be collected as part of the CWS/Case Management System so that, effective January 1, 1998, the department and county children services agencies can begin collecting data to measure effectiveness of the State's and individual counties' child welfare systems.

During our interviews, we heard that children who are reported as abused and neglected but who do not enter the child welfare system often are re-reported at a later date for another incident of abuse or neglect. However, because counties and the State do not track this information, a child may be reported several times for different incidents of abuse or neglect before a serious enough incident occurs and the child enters the county's child protective services program where his/her safety can be better ensured. Because data tracking these occurrences are important for determining the effectiveness of the emergency response process, *we recommend that the department and CWDA specify recurrences of child maltreatment as an outcome indicator and track children who are reported as abused and neglected, even if no child protective services case is formally opened after the report.*

We also found that the Department of Social Services does not know how many children have a court-approved permanent placement plan specifying a goal of adoption. We believe it is important to track this information in order to assess the performance of the State's adoptions program. Therefore, w*e recommend that the department and counties track the permanent placement plan goals for children whose permanent placement plan has been approved by a juvenile court.*

We also heard anecdotal comments from child welfare officials suggesting that less than half of the youths 16 to 18 years of age receive any independent living services. Therefore, *we recommend that the department determine whether Independent Living Program (ILP) services should be mandatory for all eligible youths rather than provided only to the youth who agree to the services and that the department and the counties enhance their efforts to provide independent living services to all youths eligible to receive ILP services.*

We also found that California's adoption program is not as effective as it should be. The number of children adopted through the child welfare system increased by only six percent between 1989/90 and 1994/95, while the number of children in foster care increased by nearly 27 percent. Further, California's adoptive placement of foster children fell 15 percent between 1991/92 and 1994/95 (from 4,197 to 3,563 placements). During the same period the number of applications received for adoptions declined by nine percent (from 6,919 to 6,342). And despite the qualifications noted above concerning national data comparisons, we believe the State's ranking among large states in adoptions per 100 children in foster care suggests a need for improvement in California's adoption program. As we indicate in Chapter 3, California, which places about 4.1 percent of its foster children in adoptive

homes, ranks near the bottom among eleven large states in this measure. Several states place more than twice as many foster children in adoptive homes.

During our review, we heard comments from child welfare officials that California was not making more adoptive placements because "adoptive families want young, healthy, Caucasian children" and because "foster care children waiting for adoption are either too old or they have serious health problems because they are drug- or substance-exposed or HIV infected." Generally, data are not available to substantiate these comments. Although younger children do appear to be more readily adopted than older children, there currently are many foster children in the same age range as those that have recently been adopted, and the ethnicity of children who have been adopted recently is not significantly dissimilar to that of the total foster care population.

Although the Department of Social Services has attempted to address the problem through its Adoptions Initiative, we believe the department needs to reconsider its approach to setting targets for counties that operate their own adoptions programs. The department's targets are based on a concept of efficiency (number of adoptions per county case worker) and not on a effectiveness.

FAMILY PRESERVATION AND HOME VISITING PROGRAMS

There has been a significant amount of recent interest in family preservation and home visiting programs. Several research studies of both programs have been conducted in various states and settings in an attempt to demonstrate the effectiveness of the programs in minimizing child maltreatment and foster care placements. Because of the potential importance of these programs for improving child welfare and reducing child welfare program costs, we reviewed the research literature on both programs to determine their effectiveness. The research we reviewed was that involving the most rigorous designs, i.e., those involving randomly assigned treatment and control groups.

Despite the number of rigorous research studies of both programs, there is little we can say about the effectiveness of either program. In both cases, the research has produced inconclusive findings about the effectiveness of the services. Moreover, few of the studies conducted follow-up research two or more years after the treatment ended. Although the few studies that conducted follow-up research also found mixed results, some follow-up studies indicated that the benefits of home visiting diminish over time. This raises questions about the need to provide ongoing, or periodic, services to a large percentage of the at-risk population, similar to what is required in substance abuse treatment programs.

Despite the lack of conclusive evidence of the effectiveness of the family preservation program, the federal government has recently made several million dollars available to states to implement the federal Family Preservation and Family Support Services Program.

Unfortunately, although there is a required evaluation component to the program, the evaluation will cover mainly process issues. Furthermore, because California has chosen to give counties the maximum amount of flexibility in implementing the program in ways that meet their own needs, it is unlikely that an evaluation methodology can be constructed to measure the effectiveness of the program in achieving specific outcomes.

In light of the lack of evidence of the effectiveness of family preservation programs and the significant amount of new federal funds being made available for the program, *we recommend that State policy-makers in the Legislature and the Administration take a conservative approach to funding family preservation programs. New State funding should be appropriated only for specific services for which there is solid evidence of success in achieving outcomes targeted by the Legislature and the Governor.*

Unlike family preservation programs, there have been few large studies of the effectiveness of home visiting programs. Despite the uncertainty about the effectiveness of home visiting in reducing child maltreatment, there is enough research suggesting that the program may have positive benefits for some families that the program's effectiveness should be further evaluated in California. We believe the department's funding of several pilot projects and the Administration's initiative for a pilot project, as proposed in the 1997-98 Governor's Budget, are reasonable approaches to testing the effectiveness of the program. However, to ensure that the Administration's initiative produces information that can be used to make future decisions on expanding home visiting programs in the State, *we recommend that prior to program implementation the department develop an evaluation methodology that is designed to demonstrate the program's effectiveness in producing desirable child welfare outcomes.*

RISK ASSESSMENT

One possible barrier to effectiveness in child welfare programs is the lack of good risk assessment instruments and processes for determining the risk of children being maltreated by their parents or other caregivers. Since 1980, there has been a movement among child welfare organizations and advocates to formalize the risk assessment process by using risk assessment instruments that are based on expert opinions about factors that predict child maltreatment. However, most of the instruments in use today have not been tested empirically to demonstrate that the factors on which they are based are statistically significant in predicting child maltreatment.

Recently, some state and county children services agencies throughout the country have attempted to improve the predictive validity of their risk assessment processes by adopting empirically-based, or "validated," risk assessment instruments. The agencies that have adopted these instruments have found that they do a better job of identifying low-risk and high-risk families than do the instruments that have not been validated.

Besides producing better risk assessments, another advantage of empirically-based risk assessment instruments is that they allow child welfare agencies to redirect scarce resources to families most in need. Currently, high-risk and low-risk cases tend to be treated alike by children services agencies, with services being provided both to families that need them and families that could get by without them. Consequently, available resources are diluted and not applied efficiently and effectively.

The 1997-98 Governor's Budget proposes a Budget Change Proposal (BCP) for the Department of Social Services to spend $1 million to develop a validated risk assessment instrument to be used statewide. However, it is not clear that a statewide, mandated risk assessment instrument is supported by county children services agencies. This causes us some concern. Several experts, including those who have studied the implementation of child welfare risk assessment instruments in other states, have noted the difficulties child welfare agencies have had implementing new risk assessment tools. If caseworkers do not accept an instrument and if their supervisors do not carefully monitor its use, the caseworkers are likely to continue making the decisions they have always made and to complete the instrument in a manner that is consistent with their already-made decision. According to one of the foremost experts in this area, the National Council on Crime and Delinquency, "improved assessments by themselves have limited impact on case practice unless there are clear expectations regarding service delivery and monitoring."

In light of preferences expressed by county children services agencies and because of the research pointing to the difficulty of implementing new risk assessment models, *we recommend that before the department spends funds to develop a validated risk assessment instrument for California the expectations of the Administration, the Legislature and county children services agencies be clearly set forth regarding implementation, and that the Administration and the Legislature obtain commitments from the county agencies to faithfully implement the instrument after it is developed. Once those expectations and commitments are set forth and obtained, we recommend that the department continue its efforts to develop a validated risk assessment model and work with county children services agencies and caseworkers to ensure that the model will be properly implemented after it is developed. We also recommend that the department continue with its plans to train caseworkers in the use of the model, but also work with the State's public and private universities to incorporate risk assessment into college curricula for social workers.*

ADMINISTRATIVE ISSUES

During our interviews with child welfare administrators and practitioners, some officials identified procedural problems that they believed were barriers to effective child welfare programs. Some of them pointed to the lack of coordination and collaboration among county agencies that provide services to children and families, such as children services agencies,

probation departments and the courts. Others noted the delays in decisions about foster children's permanency plans caused by court schedules or attitudes among court officials. Others spoke of problems within children services agencies themselves, such as lags in provision of services to families in need caused by the "hand-off" that occurs after a county intake worker, who has responsibility for a case until a dependency plan is approved by the court, transfers the case to a county caseworker. Occasionally, because of workload or other matters, the new caseworker may not check on the family until the next regularly scheduled monthly visit. In the meantime, if a parent has been directed to attend parenting training, counseling or a substances abuse treatment program, the parent may not know where or how to obtain the services and receipt of the services may be delayed for weeks, if not months.

Although these issues were beyond the scope of our study and we did not have time to pursue them, we believe that some of them may have merit. Inefficient procedures among children services agencies have major implications for child safety and for the number of children retained unnecessarily in foster care. Because of this, we believe these issues should be pursued by the Department of Social Services, perhaps through pilot projects or through forums similar to those being held today for foster care or kinship care.

PROGRAM FUNDING

Our review of the funding structures of child welfare programs identified several concerns with the manner in which programs are currently funded. In particular, we found that the current funding structure does not always support, and at times contradicts, the programmatic objectives of child welfare programs. Because of the open-ended nature of the foster care program and the funding limits placed on activities undertaken and services provided at the front end of the system (child protective services), the funding structure may in some cases encourage removing children from their homes and discourage the provision of services and treatments that may help to keep children in their homes.

We examined several alternative approaches to funding child welfare programs that we believe could improve program performance. Under the current system, the State theoretically has primary responsibility for programs such as Child Welfare Services, Foster Care, and Adoptions. However, this creates the illusion of a uniform statewide program design and administration. In fact, even though program policies for these programs are promulgated at the State level, there is little consistency among counties in the way those policies are implemented. In effect, the State has 58 different child welfare systems. In addition, the State's current method of funding child welfare programs denies program administrators the flexibility to focus program resources on interventions and services that could lead to the prevention and early detection of child abuse and the preservation or reunification of families.

Unless the State is prepared to take over operation of the child welfare system, and we do not believe that is feasible, we think the system should be modified to provide counties with both the responsibility and funding necessary to achieve both State and local program objectives. In particular, we believe that the Administration and the Legislature should reconsider the Realignment proposal that was included in the 1994-95 Governor's Budget. We believe that proposal has several advantages over the current funding system that could lead to more effective child welfare programs. First, counties would be able to restructure local programs to meet local needs. The Realignment proposal would acknowledge the differences among counties that were repeatedly stressed during our discussions with county staff and make county operations more effective by shifting decision-making on the allocation of resources to county managers who are best able to determine the needs of their communities.

Second, counties would bear the consequences of their decisions. Under the existing program structure, even though the counties make all of the decisions on how programs are administered, the State bears part of the consequences of counties' decision-making. For example, if a county decides to implement a policy which increases the length of stay of children in Foster Care, the General Fund is obligated to fund additional costs for that county. Under the Realignment proposal, counties would bear the responsibility for county decision-making.

Third, the Realignment proposal would provide a flexible funding structure that would allow counties to focus resources on prevention and early intervention services as an alternative to more expensive interventions such as Foster Care. And fourth, under the proposal the State's oversight role could be shifted from one of ensuring compliance with process-oriented regulations to ensuring the achievement of desired programmatic outcomes.

Because of these advantages, we recommend that the Administration and Legislature enact legislation to create a child welfare system patterned closely after the Realignment proposal included in the 1994-95 Governor's Budget.

CHAPTER 1
CALIFORNIA'S CHILD WELFARE SYSTEM

INTRODUCTION

California's child welfare system is a continuum of service care provided to children who are abused, neglected or exploited and their families through four primary but frequently overlapping programs: child welfare services, foster care, independent living and adoptions. Child welfare services encompasses emergency response, family maintenance, family preservation, family support, family reunification and permanent placement services components.[1] As described in the following sections, services provided through these components include emergency services, in-home care and out-of-home care to abused and neglected children and their families. When a child cannot safely remain in his or her home while the child and other family members receive child welfare services, the child will be placed in an out-of-home facility or substitute home. Depending on the care needs of the child and the availability of persons to provide the care, the child may be placed with a relative, a non-relative foster family or in a group home. The child will remain in this substitute or foster care home until he/she can be safely reunified with the family without risk of further abuse or neglect. Unfortunately, many children cannot be reunited with their family. In these instances, the children remain in foster care until emancipating from the program at the age of 18 years or until the parental rights of the biological parents are terminated and the children are freed for adoption or placed under guardianship. Children remaining in foster care at age 16 years or older may receive independent living services and activities to assist them in the transition from foster care to independent living.

Current State law places responsibility and authority for child welfare services with the State Department of Social Services and county agencies, including county welfare departments and county social services departments. In addition, the law defines child protective agencies to include police or sheriff's departments, county probation departments and county welfare departments. Further, the law requires all counties to establish and maintain specialized organizational entities within county welfare departments which have sole responsibility for the operation of the child welfare services program. In practice, the responsible county entity

[1] Federal and State law refer to these prevention, early intervention services as child welfare serivces. In practice, however, these services are more commonly referred to as "child protective services."

includes departments such as: the department of welfare, the department of social services, the department of children and family services, and the department of human services. For commonality purposes, this report refers collectively to the responsible county entity as the "county children services agency."

CHILD WELFARE SERVICES

Emergency Response Services

In 1995, California's county children services agencies received 690,005 reports of child abuse, neglect and exploitation from legally mandated reporters (such as law enforcement agencies, health care practitioners, child care custodians and teachers), family members, neighbors, concerned citizens and anonymous callers.[2] To receive these reports, State law requires county children services agencies to maintain a response system providing in-person response, 24 hours a day, seven days a week. Further, the law requires the agencies to respond immediately to any report of imminent danger to a child and within 10 calendar days to all other reports of child abuse or neglect.[3] Based on an evaluation of the report, the agency is not required to conduct an in-person response if the agency determines such a response is not appropriate.

When a children services intake worker substantiates or finds sufficient indication of abuse or neglect, action is taken immediately to ensure the safety of the child or children involved in the incident. In the majority of cases (nearly 84 percent of the substantiated cases in 1995), children remain in home with their families while the intake worker processes their cases through the child welfare system. Figure 1-1 along with the accompanying descriptions illustrates the critical juvenile dependency proceedings that will determine whether a child can continue to remain at home with his or her family, or if the child will be removed from home on a temporary or permanent basis.

Table 1-1 shows the trend of child abuse and neglect reports for the period 1988 through 1995. The data show a 29 percent increase in reports between 1989 and 1995. Neglect, including general neglect, severe neglect or caretaker incapacity, accounted for nearly 48 percent of the reports in 1995. Physical abuse and sexual abuse represented about 31 and 16 percent of the total reports, respectively.

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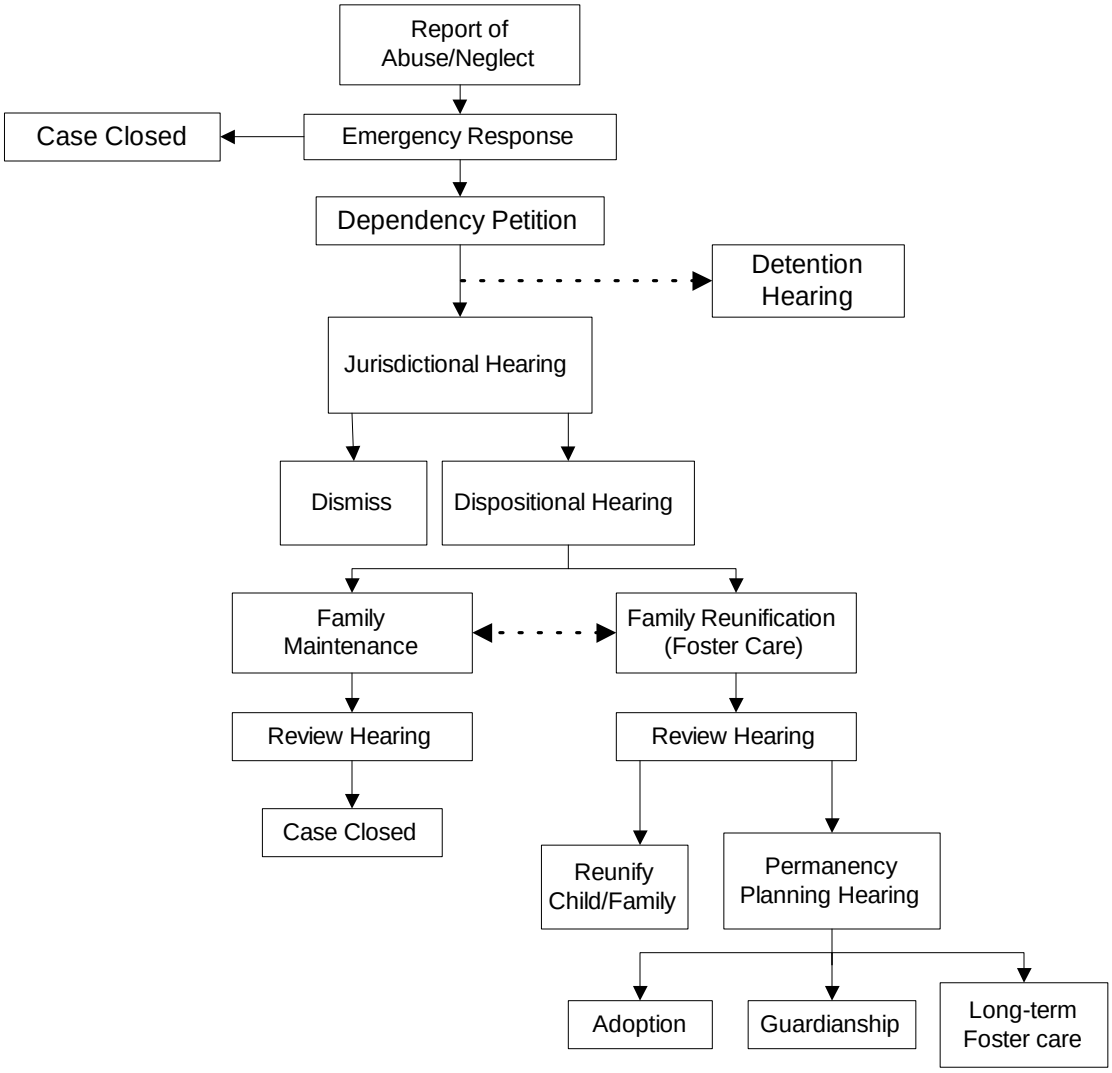
[2] California law (Penal Code Section 11165 et seq.) defines child abuse as the nonaccidential commission of injury against a child by or allowed by a parent(s), guardian(s) or other persons, and includes emotional, physical and sexual abuse. Child neglect means the failure of a parent(s), guardian(s) or caretaker(s) to provide the care and protection necessary for a child's healthy growth and development. Neglect can occur when a child is physically or psychologically endangered.

[3] Section 16501(f) of the California Welfare and Institutions Code.

FIGURE 1-1
What Happens When There Is A Report of Child Abuse/Neglect?



- **Reports of child abuse/neglect** are received by county welfare departments through Emergency Response component of the CWS Program. In some cases the county social worker may determine that the child should be placed in temporary foster care.
- A **dependency petition** is filed for each Emergency Response case that is not closed immediately, requesting that the child be declared a dependent of the court.
- A **detention hearing** is held to approve the temporary removal of the child from his or her home.
- At the **jurisdictional hearing**, the court determines whether or not abuse/neglect has occurred as stated in the petition.
- If abuse/neglect was found, a **dispositional hearing** is conducted to determine a remedy - generally, the court may order **family maintenance** or **family reunification services**.
- **Review hearings** are held, generally every six months, to review family maintenance and family reunification efforts.
- If family reunification efforts fail, a **permanency planning hearing** is held to determine the long-term plan for the child. The plan must include one of the following goals, long-term foster care placement, guardianship, or adoption.

Source: Legislative Analyst's Office, Child Abuse and Neglect in California, January 1996.

TABLE 1-1
NUMBER OF CHILD ABUSE REPORTS
BY REFERRAL REASON[a]

Referral Reason	1988[a]	1989	1990	1991	1992	1993	1994	1995
Neglect	186,810	264,044	263,836	259,650	277,542	303,583	312,947	329,679
Physical Abuse	107,669	155,977	167,886	184,681	200,346	212,138	210,997	214,707
Sexual Abuse	65,867	94,188	96,779	102,200	112,036	117,306	111,078	108,590
Other	14,451	21,549	25,281	24,683	25,678	27,915	29,272	37,029
Total	374,797	535,758	553,782	571,214	615,602	660,942	664,294	690,005
Growth over prior year	n/a	n/a	3.4%	3.2%	7.8%	7.4%	0.5%	3.9%

[a] Reports from 1988 include only those from April through December. Data may include multiple reports per child.
Sources: Child Welfare Research Center, University of California, Berkeley, Performance Indicators for Child Welfare Services In California: 1994; and California Department of Social Services Information Services Bureau, Preplacement Preventive Services For Children In California, Emergency Response Services, Family Maintenance Services, Annual Statistical Report for Calendar Year 1995.

As shown in Table 1-2, thirty-four percent (233,909 reports) of the 690,005 reports of child abuse and neglect were closed at initial assessment or transferred to other jurisdictions, resulting in 458,262 investigations, nearly 66 percent of the total reports.[4] Based on an investigation, 291,844 cases were closed based on an in-person contact, leaving 164,252 cases (about 24 percent of the total reports) with a substantiated occurrence of abuse or neglect. In 34,754 cases (21 percent of the substantiated cases), children were transferred to family maintenance services. Children were removed from their home and placed in an emergency shelter or a foster/substitute home and provided services through family reunification or permanent placement in 25,242 case (15 percent of the substantiated cases).

TABLE 1-2
NUMBER OF EMERGENCY RESPONSE (ER) CASES
BY TYPE OF DISPOSITIONS
CALENDAR YEAR 1995[a]

Type of Disposition	Number	Percent
ER Assessment Cases Closed	231,743	33.6
ER In-Person Cases Closed	291,844	42.3
ER Services Cases Closed	104,256	15.1
Transferred to Family Maintenance	34,754	5.0
Transferred to Family Reunification/Permanent Placement	25,242	3.7
Transferred to Other Jurisdictions	2,166	0.3
TOTAL	690,005	100.0

[a] Source: California Department of Social Services Information Services Bureau, Preplacement Preventive Services For Children In California, Emergency Response Services, Family Maintenance Services, Annual Statistical Report for Calendar Year 1995.

[4] The 458,262 investigations represents all ER dispositions except "ER assessment cases closed."

Family Maintenance

If a report of child abuse or neglect is substantiated, a county children services agency may offer, or a court may order, in-home protective services for the child and the family to prevent or remedy the abuse or neglect without separating the child from his or her family.[5] These services can include counseling, parent training, respite care, temporary in-home caretakers and others. In most circumstances, these services are available to the child or family for six months only. However, services may be extended for one additional six-month period if the agency can show that the objectives of the case plan can be achieved within the extended time. Also, certain provisions of the law allow family maintenance services to an individual to extend beyond twelve months until the individual reaches 18 years of age.[6]

Family Preservation

A county children services agency may provide intensive "family preservation" services to families whose children will be placed in out-of-home care without the provision of services or to families whose children can be returned to their families with the provision of services. These services may include, but are not limited to, counseling, mental health treatment and substance abuse treatment services, parenting training, respite, day treatment, transportation and homemaking services. Further, the agency may provide services to the family without time limitation until the court dismisses the child dependency case. However, the county legally may not expend more funds for services under this program than that amount which the county would expend for placement in out-of-home care.

The following definition of family preservation services has been used for state and local planning efforts under the federal legislation on Family Preservation and Family Support Program (FPFSP), part of the Omnibus Budget Reconciliation Act of 1993:

> *Family preservation services typically are designed to help families alleviate crises that might lead to out-of-home placement of children; maintain the safety of children in their own homes; support families preparing to reunify or adopt; and assist families in obtaining services and other supports necessary to address their multiple needs in a culturally sensitive manner. (If a child cannot be protected from harm without placement or the family does not have adequate strengths on which to build, services to preserve that family are not appropriate.)*[7]

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[5] County children services agencies also provide family maintenance services to families who voluntarily requests such services even though a report of child abuse or neglect has not been substaintiated by the county.
[6] Sections 11254 and 16506 of the California Welfare and Institutions Code.
[7] California Department of Social Services, California's Family Preservation and Support Program, Five-year Plan 1994-1999, page 3.

Family Support

If a child is a probable risk to soon be within the jurisdiction of a juvenile court or has returned to the family unit following out-of-home placement, the county children services agency may provide the family with support services. The following definition of family support services has been used for state and local planning efforts under the federal legislation on Family Preservation and Family Support Program, part of the Omnibus Budget Reconciliation Act of 1993:

> *Family support services are primarily community-based preventive activities designed to alleviate stress and promote parental competencies and behaviors that will increase the ability of families to successfully nurture their children; enable families to use other resources and opportunities available in the community; and create supportive networks to enhance child-rearing abilities of parents and help compensate for the increased social isolation and vulnerability of families.*[8]

Family Reunification

When a child cannot safely remain at home and has been placed in foster care, the children services agency may provide services to the child, the parent(s) or guardian(s), and the foster family to reunite the child with his or her parent or guardian. By law, the services are time-limited activities designed to prevent or remedy abuse, neglect or exploitation of the child. Unless other action is taken to terminate the services prior to the time limitation, such as the court's dismissal of the dependence, further reunification efforts are determined to be inappropriate or the child emancipates from foster care, reunification services are limited to 12 months with the possible extension to a total of 18 months. Agency staff are required to develop a case plan identifying the service needs of the child and family to facilitate family reunification. The juvenile or family court approves and periodically reviews the viability of the case plan.

Current law also allows a county children services agency to provide family reunification services to children and families when an out-of-home placement was voluntarily accepted by a family without court adjudication. However, the county and the parent(s) or guardian(s) must have a written agreement specifying the terms of the voluntary placement and the services are limited to six months. Depending on the availability of federal funds and under certain circumstances, the voluntary placement services may be extended for an additional six month period but the services may not exceed a total of 12 months.[9]

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[8] Ibid.

[9] California Welfare and Institutions Code Section 16507.2 et. seq. The law allows the additional period if a parent, guardian or a child is in a residential treatment program, is demonstrating progress and is likely to complete the program within the extended period. While current federal law limits federal funding to six months, the Department is seeking a waiver to extend the funding period to 12 months.

Permanent Placement

Within 30 calendar days of the initial in-person investigation or removal date but no later than the date of the jurisdictional hearing, the county children services agency must have completed a case plan for the child which must include, among other items, a case plan goal. In priority order, the county worker must consider whether the child can be safely maintained in his or her home when protective services are provided to the family or if the family potentially can be successfully reunited within the time frames allowed for reunification services. If the county children services agency finds, and the court agrees, that children cannot safely live with their parents and are unlikely to return to their own home, the children services agency is required to provide permanent placement services.

When permanent placement has been identified as the case plan goal, the county staff are required to first determine whether the child should be placed for adoption. If adoption is not a viable option for the child, the staff must then consider placing the child into a guardianship arrangement. Only as the last option when adoption and guardianship are not possible, county staff will recommend long-term foster care placement. Table 1-3 displays the case plan goals for children in foster care during fiscal year 1995/96.[10]

TABLE 1-3
AVERAGE MONTHLY CASES BY CASE PLAN GOAL
FOR FISCAL YEAR ENDED JUNE 1996[a]

Case Plan Goal	Number of Children 1994/95	Number of Children 1995/96	Percent of 95/96 Total Children
Total Children	95,498	98,281	100.0
Return to Parents/Guardians	59,019	61,118	62.2
Adoption	6,725	6,513	6.6
Adoption with Sibling	724	877	0.9
Guardianship	7,366	7,614	7.7
Self-Maintenance	596	673	0.7
Long term Foster Care - Relative	9,988	10,361	10.5
Long-term Foster Care - NonRelative	10,823	10,868	11.1
Invalid Case Plan Goal	256	257	0.3

[a] Source: California Department of Social Services, Foster Care Information System, Report FCI582-1

[10] The data in Table 1-3 reflect case plan goals and do not necessarily reflect permanency plan goals. Because a child's case plan is updated continuously while the child remains in the child welfare system, the child's goal may change and the initial case plan goal may not be the same as the final permanency plan. The department advised us that counties may not update the database in a timely manner. Nonetheless, department staff believe the above data reasonably reflect actual placement goals based on court approved permanent placement plans.

FOSTER CARE

When children cannot safely remain in their own home without risk of abuse or neglect, they are removed from home and put into a temporary placement. A child can be moved into temporary placement based on the initial in-person response or when a county case worker has considered and/or used in-home services and has determined that the child cannot be safely maintained in his or her own home. Temporary placement consists of emergency shelter care or out-of-home respite care which includes a home of a relative, a licensed foster family home, a licensed small family home or a licensed group home. Placement is based on the least restrictive, most family-like environment; the child's health, age, sex and special needs; and protective needs of the community. Placement in an emergency shelter is limited to 30 calendar days but placement into a temporary foster care home could be as long as 18 months, or until the child returns home or a permanent placement plan is adopted by the juvenile court.[11]

While a child is placed in temporary care, efforts are made to remedy or prevent further abuse and neglect so that the child can be safely reunified with his or her family. During this period, the county children services agency case worker works with the parent(s) or guardian (s), the foster parent(s), the child if old enough to participate in the case planning, other family members, relatives, service providers and other interested parties to identify child and family needs, and ensure the delivery of necessary services and treatment programs. These services and treatments programs are included in the child welfare services discussed in the prior section of this chapter.

When a child is placed in out-of-home care, placement may be in one of four types: the home of a relative (i.e., kinship care); a foster family home; a foster family agency (FFA) home; or a group home. Foster family homes are licensed to serve no more than six foster children, whereas, group homes vary in size from small family style homes to larger institutional settings. Although the foster care grant to a foster family home may be supplemented for care of children with special needs, the basic grant only pays for board and room costs. Based on 1995/96 rates, the monthly grant varies in payment from $345 to $484. Because group homes generally serve children with special needs, the monthly grant for these homes includes payment for special services and varies from $1,183 to $5,013. By law, placement with a FFA home serves as an alternative to group home placement. These homes operate under an agreement with nonprofit foster family agencies which provide professional support services to their member foster family homes. The agencies are paid from $1,283 to $1,515 a month per foster child and each agency pays its member homes according to its agreement with the home. Based on 1994 information, the licensed capacity for foster family homes was 21,891; for FFA homes, the capacity was 14,409; and for group homes, the capacity was 11,624.

[11] The 30 day limit applys to placements funded with the use of Title IV-B funds. Temporary foster care homes or group homes use Title IV-E Emergency Assistance and county only funds for emergency shelter care.

Tables 1-4 through 1-8 display information about children in the foster care system, using the latest available data.[12] As shown in Table 1-4 the foster care population increased 34 percent during the period 1989 through 1995. The Table also shows that during each year of this period, more children entered foster care placement than exited from out-of-home care.

TABLE 1-4
END OF YEAR FOSTER CARE POPULATION, ENTRANCES, EXITS AND NET CHANGE: 1989-1995[a]

	1989	1990	1991	1992	1993	1994	1995
Foster Care Population (FCP)	67,553	70,866	72,089	74,668	78,941	85,308	90,325
Entrances	33,101	30,893	29,961	30,515	32,617	35,056	33,184
Exists	22,060	27,580	28,738	27,936	28,344	28,689	28,167
Net Change	11,041	3,313	1,223	2,579	4,273	6,367	5,017
FCP Growth over prior year	n/a	4.9%	1.7%	3.6%	5.7%	8.1%	5.9%

[a] Source: Child Welfare Research Center, University of California, Berkeley, Performance Indicators for Child Welfare Services In California: 1995, Sacramento, CA: California Department of Social Services, 1997, page 17.

Table 1-5 displays the age distribution of children in foster care for the years 1989 through 1995, showing that the greatest number of foster children are in the 6-12 age category. The Table also compares the foster care population with California's total population under age 18. As the data show, the foster care population increased at a rate almost two and one half times as great as the rate of growth in the State's under-18 population (39 percent growth compared to 16 percent). In addition, the ratio of foster care children per 1,000 children in California shows nearly a 20 percent increase over the six-year period.

In Table 1-6, the 1995 foster care population is categorized by ethnicity. The data show that more African American children are placed in out-of-home care than any other ethnic group, 37 percent compared to 36 percent for Causasian children and 24 percent for Hispanic children. However, when viewing 1995 California population data, the Caucasian children under the age 18 years represented about 42 percent of the total under age 18 population whereas African American children represented less than 8 percent.

Using year-end data for three consecutive years, Table 1-7 compares the number of federally eligible foster care children to the number of non-federally-eligible children, separating the information between the welfare caseload and the probation caseload. The Table also includes the number of children receiving foster care services but whose board and room

[12] We found that the foster care population number varies by source of information. According to Department of Social Services staff, several of the reports produced by its Information Services Bureau are based on preliminary information and may differ from the more complete/final data used by the Child Welfare Research Center at University of California, Berkeley. Consequently, the numbers may differ from one table to another.

TABLE 1-5
CHILDREN IN FOSTER CARE IN CALIFORNIA
AGES 0 TO UNDER 18: 1989-1995[a]

Age Group	1989	1990	1991	1992	1993	1994	1995	Percent of 1995 Total
< 1	4,636	4,458	3,818	3,981	3,830	4,002	4,132	5%
1-2	9,611	10,945	10,495	9,937	10,197	10,557	10,904	12%
3-5	12,056	13,415	13,913	14,341	15,038	16,123	17,331	20%
6-12	23,773	25,690	26,493	27,486	29,114	31,440	34,813	40%
13-17	12,662	14,704	15,524	16,466	17,406	18,930	20,186	23%
Total	62,738	69,212	70,243	72,211	75,585	81,052	87,366	100%
Growth over prior year	n/a	10.2%	1.5%	2.8%	4.7%	7.2%	8.8%	n/a
California under age 18 years population	7,670,041	8,086,369	8,102,340	8,361,204	8,546,974	8,716,983	8,879,836	n/a
Growth over prior year	n/a	5.4%	0.2%	3.2%	2.2%	2.0%	1.9%	n/a
Foster Care per 1,000 children in California under age 18	8.2	8.6	8.7	8.6	8.8	9.3	9.8	n/a

[a] Sources: Child Welfare Research Center, University of California, Berkeley, Performance Indicators for Child Welfare Services in California: 1995, page 55; and Department Of Finance, Demographic Research Unit, special reports.

TABLE 1-6
CHILDREN IN FOSTER CARE
BY AGE AND ETHNICITY, 1995[a]

Age Group	African American	Caucasian	Hispanic	Other	Total
< 1	1,261	1,699	1,082	87	4,129
1-2	3,570	4,183	2,900	248	10,901
3-5	6,526	6,075	4,323	403	17,327
6-12	13,854	11,891	8,275	774	34,794
13-17	7,325	7,478	4,770	595	20,168
Total	32,536	31,326	21,350	2,107	87,319
Ethnic Group as Percentage of Total Foster Population	37.3%	35.9%	24.4%	2.4%	100.0%
1995 under age 18 population by Ethnic Group as percentage of total California under age 18 population[b]	7.8%	41.6%	39.7%	10.9%	100.0%

[a] Source: Child Welfare Research Center, University of California, Berkeley, Performance Indicators for Child Welfare Services In California: 1995, page 69.

[b] Source: California Department of Finance, Demographic Research Unit, Population Estimates for California State and Counties, Report 95 E-2, May 1996 and special report on ethnic populations

TABLE 1-7
CHARACTERISTICS OF CHILDREN IN FOSTER CARE
STATUS AS OF THE END OF
THREE CONSECUTIVE YEARS: 1994-1996[a]

Characteristics	December 1994	December 1995	December 1996	Percent of 1996 "Total Cases Open"
Total Welfare Cases Open on Last Day of Month	89,188	92,267	98,466	100.0
Federal Foster Care	51,898	55,554	60,791	61.7
Nonfederal Foster Care	14,622	13,952	13,972	14.2
Services only/Non-F.C. funded	22,668	22,761	23,703	24.1
Total Probation Cases Open on Last Day of Month	4,887	4,652	5,633	100.0
Federal Foster Care	2,334	2,497	2,829	50.2
Nonfederal Foster Care	2,538	2,131	2,773	49.2
Services only/Non-F.C. funded	15	24	31	0.6

[a] Source: California Department of Social Services, Information Services Bureau, Report: FCI520

costs are funded by non-foster-care funds.[13] Based on 1995 data, more than 60 percent of the foster care population is eligible for federal funds.[14]

Placement in out-of-home care by placement type for the years 1989 through 1995 is displayed in Table 1-8. While kinship care is the largest placement type, FFA homes was the fastest growing type, increasing by 488 percent during the six-year period. During the same period, placement in foster family homes decreased nearly three percent but showed a small increase between 1994 and 1995.

As these data indicate, the growth in kinship care accounted for 57 percent of the growth in foster care between 1989 and 1995, and the growth in the number of children in foster family homes accounted for 34 percent of the growth. Together, growth in kinship placements and growth in foster family agency placements accounted for 91 percent of the total growth in foster care since 1989.

[13] The "Services only" category represents children in out-of-home placement whose board and room costs are paid with funds other than federal and non-federal foster care funds. The majority of children in this category are not AFDC eligible and generally are placed in the home of a relative who then may receive AFDC funds for the child; however, the rate is at least 15 percent less than the federal/nonfederal foster care rate.

[14] As described in more detail in Chapter 8, for eligible foster care grants, federal funds pay 50 percent of the costs, the State pays 20 percent and the county pays 30 percent.

TABLE 1-8
CHILDREN IN FOSTER CARE
BY PLACEMENT TYPE: 1989-1995[a]

Placement Type	1989	1990	1991	1992	1993	1994	1995	Percent of 1995	6 Year Growth
Kinship	26,141	29,523	29,859	31,625	33,961	36,954	40,251	46%	54%
Foster Homes	27,906	29,267	28,608	27,685	26,970	26,947	27,127	31%	(2.8%)
FFA Home	1,698	2,760	3,714	4,483	5,495	7,275	9,990	12%	488.3%
Group Home	5,474	6,044	6,335	6,514	6,921	7,307	7,348	8%	34.2%
Other	1,117	1,166	1,327	1,545	1,860	2,196	2,294	3%	105.4%
Total	62,336	68,760	69,843	71,852	75,207	80,679	87,010	100.0	41.4%

[a]Source: Child Welfare Research Center, University of California, Berkeley, Performance Indicators for Child Welfare Services In California: 1995, page 51.

Kinship Care

While children suffer from their parents' abuse and neglect, a child's removal from his or her own home and separation from his/her parents can be an equally traumatic and often a devastating experience for the child. To lessen the trauma and to maintain the child's well being, many child welfare experts encourage the placement of children who are removed from their own homes into the home of a blood relative, god-parent, step-parent, a member of a tribe or clan, or other adult who has a connection to the family.[15] Many experts believe that maintaining a child's family connection preserves a sense of roots, a sense of belonging, and a sense of history or culture. In their opinion, kinship care is an essential child welfare service.

As shown in Table 1-8, more than 40,000 (nearly 46 percent) of the children in foster care in 1995 lived in a kinship care home with the majority living in the home of a grandparent. This represents a 54 percent growth in kinship care over a six year period.

One of the concerns raised by Department of Social Services staff is the amount of time children spend in kinship care compared with children placed in non-kin foster family homes. According to the Child Welfare Research Center of the University of California, Berkeley, based on the latest information from the State's Foster Care Information System:

[15] As used in the California Welfare & Institutions Code Section 319(d), "relative" means an adult who is related to the minor by blood or affinity, including all relatives whose status is preceded by the words "step," "great," "great-great," or "grand." However, only the following relatives shall be given preferential treatment for placement of the minor: an adult who is a grandparent, aunt, uncle, or sibling of the minor.

"The medium length of stay was 20 months for children in Kinship Homes, 13 months for children in Foster Homes, 25 months for children in FFA homes, 12 months for children in Group Homes, and nine months for children in other placements. While 25 percent of the children left care in two months from Foster and Group Homes, seven months passed before 25 percent of the children left FFA Homes and eight months went by before 25 percent left Kinship Homes."[16]

The reasons for children remaining in kinship care longer than foster family homes are not fully understood, but many observers believe that kin are less likely to pursue adoption or legal guardianship than are other foster parents because they do not wish to sever the rights of the children's parents, their kin, and because of the fiscal disincentives associated with adoption and guardianship. Children who are placed under guardianship with a relative lose their eligibility for federal foster care benefits and non-federally eligible children who are adopted by a relative receive an AFDC grant rather than a foster care grant; however they may be eligible for adoptions assistance. Therefore, fearing the loss of the benefits, many relatives are reluctant to take legal custody of the children.[17]

California's child welfare experts also find inconsistent policies and practices among county children services agencies regarding the placement of children in kinship care. Child welfare officials noted a disparity in services provided to kin and non-kin foster care parents such as training and support assistance.

To address these issues in a collaborative manner, the Department of Social Services and the County Welfare Directors Association co-sponsored a *California Policy Summit on Kinship Care* in February 1996. As one outcome of the conference and the discussions about kinship care, in its November 1, 1996 *California's Child Welfare Waiver Proposal*, the Department of Social Services requested a waiver to federal requirements to continue foster care payments on behalf of children living with relatives after dismissal of dependency and the establishment of custody or guardianship.

INDEPENDENT LIVING

In accordance with provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272),[18] the State and county children services agencies have established Independent Living Programs (ILP) to provide specialized services to children who are declared a ward or dependent child of a juvenile court, placed in out-of-home care,

[16] Child Welfare Research Center, University of California, Berkeley, Performance Indicators for Child Welfare Services In California: 1995, Sacramento, CA: California Department of Social Services, unpublished, 1997, p. 86.
[17] As discussed in Chapter 8, the AFDC rate is less than the foster care rate ($511 compared to $541 per month).
[18] The Independent Living Program initially was implemented as a temporary program but was later established as a permanent program retroactively to October 1992.

and who are age 16 years or older. The purpose of the program is to enable eligible youth to achieve self sufficiency prior to leaving the foster care system. Through the program, the youth receive independent living skills assessment, training, and other services so that when they exit the child welfare system, they can make the difficult transition to independent living. For each youth in foster care placement age 16 years or older, the county children services case worker must develop a written transitional independent living plan which describes the programs and services that will assist the youth prepare for independent living. This plan must be incorporated into the youth's case plan.

Independent Living Program services are available to youths in foster care aged 16 years through age 18. However, if a youth becomes a full-time student in a secondary school or an equivalent vocational-technical training prior to reaching the age 18, the youth is eligible for services until the age of 19. Counties have the option of providing services to youth emancipating from foster care until the age of 21.

Services offered youth under the ILP include: independent living skills classes at community colleges providing youth with knowledge pertaining to securing a job, money management, making decisions and choices, and building self-esteem; skills training; financial assistance with college or vocational schools; and transitional housing. However, services under this program are subject to the availability of federal funds allotted for this purpose.

In a 1994/95 report on the ILP,[19] the author describes the community colleges cooperative efforts with the Department of Social Services and local communities to improve training and support services for teenage foster youths. The report states that 52 community colleges throughout California were providing classes to the youths and their care providers. Based on statistical information collected for the report, unduplicated participants included 3,259 foster care providers and 2,407 foster youths, representing 13 percent of the approximately 18,000 foster care youths aged 16 to 18 years.

Evaluation of the Independent Living Program

State law required that the Department of Social Services conduct a comprehensive evaluation of the ILP by January 1, 1995.[20] To date, however, the department has not completed the evaluation. In an April 1996 letter to the Acting Secretary to the Senate, State of California, the department stated that data submitted by counties was insufficient for purposes of conducting the evaluation. As a result, in addition to collecting data through a statewide survey, the department was working with the Center for Child and Family Policy Studies at the University of California, Los Angeles, to gather information for the evaluation.

[19] California Community Colleges Foundation, Independent Living Program, Annual Report Fiscal Year 1994-1995. Publication date unknown.
[20] Welfare and Institutions Code Section 10609.3(a).

When sending its letter to the Senate, the department anticipated that the evaluation would be completed by December 31, 1996.

ADOPTIONS[21]

Most child welfare experts agree that a permanent, stable living environment is in a child's best interest. Consequently, when child welfare reunification services for children and parents are unsuccessful or inappropriate for reunifying the family, these experts believe that the child welfare system should move quickly to establish permanency for children. While guardianship and long-term foster care are possible permanent placement alternatives, children services case workers are required first to conduct an analysis of the likelihood that a child will be adopted if the parental rights are terminated by the court. If the court finds that the child likely would be adopted, the court can authorize the appropriate county or state agency to proceed with termination of parental rights. However, prior to terminating the rights, the court also must consider whether the child's foster parents, including relative caretakers, are unable to adopt the child because of exceptional circumstances but are willing and capable of providing for the child with a permanent and stable environment. Further, the court must consider whether removal of the child from the foster parent would be seriously detrimental to the emotional well-being of the minor.

Since 1980, federal and State law have been enacted to expedite the adoption. Underlying those laws was a belief that, too often, children unable to return to their families "drifted" in the foster care system without a permanent family until they emancipated from the system; few children were adopted. However, with the passage of the federal Adoption Assistance and Child Welfare Act of 1980 (Public Law 96-272) and subsequent State legislation, California initiated action to place priority on adoption as the preferred permanent placement alternative.

Despite these earlier actions, the number of adoptions has not increased in relation to the number of children in foster care who entered permanency planning. Table 1-9 compares adoptions by type of agency for the six-year period beginning 1989/90. In addition, the Table shows a comparison of adopted children to the foster care population as well as a comparison of adopted children to whose case plan goal was adoption. Using the most recent statewide published adoptions data, the Table shows that, for fiscal year 1994/95, four percent of the children in foster care were adopted. Also, the data show that less than half of the children whose case plan goal was adoption were, in fact, adopted during that year.

[21] Three types of adoptions are regulated by the State: "agency" (i.e., "relinquishment") adoptions; "private" adoptions where the birthparent(s) voluntarily place their child for adoption; and "inter-country" adoptions. The Department of Social Services is responsible for licensing public and private adoption agencies, including 28 counties which have elected to carry out the adoptions program within their counties. The remainder of the State is served by the department through six regional offices as well as private adoption agencies. In this report, we focus only on "agency" adoptions as these adoptions include children adopted through the child welfare system. (W&I Code Section 366.25 et. seq.)

TABLE 1-9
ADOPTIONS BY TYPE OF AGENCY: 1989/90 - 1994/95
AND COMPARISONS OF TOTAL ADOPTIONS TO THE
FOSTER CARE POPULATION AND THE NUMBER OF
ADOPTABLE CHILDREN

	1989/90	1990/91	1991/92	1992/93	1993/94	1994/95
County Adoption Agencies	2,675	2,953	3,375	3,440	2,953	2,799
CDSS District Offices	170	229	272	248	290	220
Private Adoption Agencies	516	539	550	469	411	544
TOTAL	3,361	3,721	4,197	4,157	3,654	3,563
Foster Care Population[b]	69,210	71,477	73,379	76,804	82,125	87,816
Total Adoptions as percent of Foster Care Population	4.9%	5.2%	5.7%	5.4%	4.5%	4.1%
Adoptable Children[c]	Published data are not available for these years.					7,449
Adoptions as percent of adoptable children	n/a	n/a	n/a	n/a	n/a	47.8%

[a] Source: California Department of Social Services, Information Services Bureau, Adoptions In California, Agency, Independent, Intercountry, Annual Statistical Report, multiple years, Table 1.

[b] The foster care populations are mid-year estimates calculated by using half of each year's population from Table 1-4 and adding two consecutive years; e.g., 1989 (67,553/2) + 1990 (70,866/2) = 1989/90 (69,210).

[c] Children with case plan goals of "adoption," and "adoption with sibling." See Table 1-3 for the 1994/95 data.

Information showing the number of adoption applications received and approved between 1990/91 and 1994/95 is presented in Table 1-10. The data show that, on average, only 47 percent of the applications were disposed of during a year. Also, more applications were approved each year than "homes used" in the same year but the number of applications received per year declined by 28 percent over the four year period.

Characteristics of adopted children are compared, in Table 1-11, to all children in foster care and to the children whose case plan goal was adoption. While characteristics information for foster children and those whose goal was adoption is available for fiscal year 1995/96, the most recent published information for adopted children is fiscal year 1993/94. Although the data represent different years, the information shows that with the exception of age, the characteristics of adopted children look reasonably similar to the foster care population as a whole. The median age for adopted children was less than three years; for adoptable children, the median was above six-years; and for the total foster care population, the median was eight years.

TABLE 1-10
AGENCY ADOPTION APPLICANTS
REQUESTING CHILDREN: 1990/91 - 1994/95[a]

Activity	90/91	91/92	92/93	93/94	94/95
Requests received during year	27,840	26,383	25,014	22,861	23,428
Applications received during year	8,152	6,919	6,536	5,928	6,342
Prior year carry over applications	8,954	9,414	8,830	7,939	6,716
TOTAL APPLICATIONS	17,106	16,333	15,366	13,867	13,058
Applications approved during year	3,584	3,769	3,547	3,618	3,323
Applications denied, withdrawn, other	4,150	3,649	3,786	3,509	2,645
TOTAL DISPOSED	7,734	7,418	7,333	7,127	5,968
Homes used	3,042	3,435	3,481	3,087	2,938
Homes available	3,231	3,256	2,880	2,857	2,792

[a] Source: California Department of Social Services, Information Services Bureau, Adoptions In California, Agency, Independent, Intercountry, Annual Statistical Report, multiple years, Table 2.

To increase adoption of California's foster care children, through the 1996 Budget Act, Governor Wilson initiated an Adoptions Initiative which over the next five years intends to combine increased local assistance with reforms in the adoptions program and agency practices.[22] Key provisions of the initiative include:[23]

- Augmenting adoption program funding to public agencies linked to increased productivity through individual county performance agreements.

- Removing barriers that keep children in long-term foster care and impede public agency productivity by implementing statutory, program, policy and practice reforms including: expediting permanency for infants and toddlers; expediting adoption of siblings by the same family; developing a statutory proposal for a streamlined kinship adoption process; and developing a statutory proposal to allow older children to retain positive relationships with birth family members.

The Department of Social Services is moving forward with implementation of the Initiative's objectives. It established an Adoptions Initiative Bureau, staffed by redirecting 2.5 positions from within the department to augment 7.5 positions created through the Budget Act. In addition, the department reached an agreement with the counties to loan 6.5 county-funded

[22] Co-sponsored by the Department of Social Services, the California Welfare Directors Association and the California Association of Adoption Agencies, a November 1995 conference, *California Adoptions into the Twenty-first Century*, laid the foundation for much of the Governor's initiative.
[23] California Department of Social Services, The Governor's Adoptions Initiative, Progress Report, Report to the Legislature November 1, 1996.

TABLE 1-11
CHARACTERISTICS OF FOSTER CARE POPULATION,
ADOPTABLE CHILDREN AND ADOPTED CHILDREN
FOR SELECTED YEARS

	1995/96 Total Foster Care[a]		1995/96 Adoptable Children[a, b]		1993/94 Adopted Children[c]	
Characteristic	Number	Percent of Total	Number	Percent of Total	Number	Percent of Total
Sex:						
Male	50,110	51.0%	3,765	50.9%	1,606	50.1%
Female	48,141	49.0%	3,626	49.1%	1,599	49.9%
TOTAL	98,281	100.0%	7,391	100.0%	3,205	100.0%
Age:						
less than 1	3,423	3.9%	117	1.6%	409	12.8%
1	5,379	5.5%	400	5.4%	272	8.5%
2	5,834	6.0%	762	10.3%	556	17.3%
3	5,786	5.9%	693	9.4%	472	14.7%
4-5	12,037	12.3%	1,300	17.6%	619	19.3%
6-7	11,895	12.1%	1,256	17.0%	386	12.0%
8-10	15,811	16.1%	1,388	18.8%	324	10.1%
11-13	14,335	14.6%	845	11.5%	120	3.8%
14-18	23,446	23.9%	614	8.3%	47	1.5%
TOTAL	97,946	100.0%	7,375	100.0%	3,205	100.0%
Ethnicity:						
White	35,496	36.1%	2,980	40.3%	1,184	36.9%
Hispanic	24,923	25.4%	1,740	23.6%	923	28.8%
Black	35,193	35.8%	2,520	34.1%	875	27.3%
American Indian/ Alaskan Native	1,033	1.0%	63	0.9%	18	0.6%
Filipino	303	0.3%	18	0.2%	15	0.5%
Asian/Pacific Islander	959	1.0%	46	0.6%	66	2.0%
Other	374	0.4%	24	0.3%	124	3.9%
TOTAL	98,281	100.0%	7,391	100.0%	3,205	100.0%

[a] Source: California Department of Social Services, Information Services Bureau, Characteristics of Children by Case Plan Goals Average Monthly Cases For Fiscal Year Ended June 1996, Report: FCI583-1.

[b] "Adoptable children" is defined as children with a case plan goal of "adoption" or "adoption with w/sibling(s)."

[c] Source: California Department of Social Services, Information Services Bureau, Characteristics of Agency Adoptions in California, July 1993 - June 1994, Tables 3, 5 and 9.

positions to the Bureau. The Bureau will develop policy reforms proposed by the newly created Adoptions Policy Advisory Council and provide technical assistance to counties to identify barriers to effective adoption services.

Through the Initiative, incentive funding was provided to counties to achieve an adoptions performance goal of 10 adoptive placements per full time equivalent (FTE) adoptions case worker per year. By January 1, 1997, 23 of the 28 counties providing adoption services have signed individual county performances agreements with the State.

We commend the department for its actions to increase the number of adoptions of children entering the child welfare system. We question, however, the efficacy and fairness of a goal that is based on adoptive placements per FTE per case worker, which emphasizes efficiency rather than effectiveness. This goal does not recognize the effectiveness of an agency's adoptions practices, i.e., the number of adoptive placements relative to the number of children available for adoptive placements. Some agencies may be very effective in placing a high percentage of foster care children with adoptive parents whereas other agencies may place a relatively low number of children. The department's current goal fails to recognize this difference. Furthermore, we know of no analysis that demonstrates that a target of 10 adoptions per FTE case worker is realistic for each county.

To assess the reasonableness of the department's goals for individual counties, we attempted to obtain data on the number of adoptable children in California's child welfare system, i.e., children whose biological parents' parental rights had been terminated by the court. However, the department could not provide us with this data. As an alternative, we looked at the ratio of the adoption targets for each county to the county's foster care population. We found that the department's targets would require San Luis Obispo, Monterey, Merced and Santa Cruz Counties to obtain adoptive parents for more than 20 percent of their foster care population, while requiring San Francisco, Fresno, Contra Costa Los Angeles, and Alameda Counties to find adoptive parents for less than 6 percent of their foster care population. This wide disparity raises questions about the equity of the department's goals for individual counties. Consequently, *we recommend that the Department of Social Services reassess it adoption targets for individual counties, giving more weight to the percentage of foster children each county must place with adoptive parents in measuring county output.*

Adoptions Assistance Program

Recognizing that adoptive parents often experience financial difficulty meeting the special needs of children who formerly were placed in California's foster care system, the State Legislature created the Adoptions Assistance Program (AAP). In creating the program, the Legislature intended the services to benefit children in foster care by providing the security and stability of permanent homes.

The department and counties who opt to carry out the adoptions program are required to determine the eligibility for participation in the program and have a signed adoption assistance agreement with the adoptive parents that stipulates the need for, and the amount,

of the AAP benefit.[24] The signed agreement must specify the duration of the assistance and a renewal date which cannot exceed two years. Further, the financial payment shall be considered only after full documentation of actual costs to be incurred because of the child's qualifying condition, as well as an assessment of the adoptive family's resources to pay for the needed services.

In part, the amount of the AAP cash benefit is guided by the income level of the adoptive family. If the family's income is below the statewide median income, the family may qualify for an amount up to the State-approved basic foster care rate plus any State-approved specialized care increment for which the child would be eligible to receive if in foster care. If the family's income is above the statewide median income, the family is not entitled to any portion of the foster care rate but may qualify for benefits based on the State-approved specialized care increment the child would be eligible to receive if in foster care.[25] Based on the most recent published statewide information (1993/94), 75 percent of the adopting families received some level of AAP benefits.

[24] The amount of financial assistance offered by a county will vary from county to county depending on the resources available in the county for this purpose. The county must have a State-approved plan that identifies the type and amount of assistance offered by the county.
[25] California Welfare and Institutions Code, Section 16119(d).

CHAPTER 2
MEASURING THE EFFECTIVENESS OF CALIFORNIA'S CHILD WELFARE SYSTEM

INTRODUCTION

> *"... Children should reach adulthood having experienced a safe, healthy, and nurturing childhood which prepares them to become responsible and contributing members of the community."*[26]

When children are removed from their homes because of abuse, neglect or exploitation and made dependents of the State and county child welfare systems, does the system improve the well-being of the children enabling them to reach adulthood in a safe and healthy manner? Are the children "better off" under the protection of the child welfare system than they were at home with their families? When the child welfare system intrudes into the daily lives of a family whose children have been abused or neglected, do child welfare services improve the quality of family life so that the children can remain at home with other family members in a safe, quality family environment? These and other similar questions are frequently asked of child welfare officials, researchers and other observers of the child welfare systems, yet, the answers to the questions may not be well known.

Public child welfare officials, children's advocates, parents and other concerned individuals have long had an interest in knowing whether children's well-being improved as a result of child welfare services. For years, researchers have explored the improvements, or lack of improvements, to children receiving publicly funded services. Until recently, child welfare officials and others relied largely on descriptive social research studies and process evaluations for program information when making funding and policy decisions.[27] In the

[26] Los Angeles County Children's Planning Council, Improving Outcomes for Children and Families in Los Angeles County: Strategic Directions for Change, undated.

[27] Process evaluations attempt to determine how well services were delivered; e.g., were the intended services delivered, were they delivered according to a prescribed time schedule and in what manner were the services delivered. These evaluations generally do not measure the outcomes of services; i.e., to what extent did the service accomplish the intended outcome (or goal/objective).

past 15 to 20 years, however, faced with a growing foster care population and a shortage of funds, the officials have become increasingly aware of the importance of information about child welfare service outcomes. In the absence of information on outcome effectiveness, the officials often have little solid evidence for continuing or discontinuing a child welfare program or service.

Many child welfare experts say the current child welfare system is flawed; the system is not working to protect children. They say too many children "drift" in foster care homes, spending years in out-of-home placement without establishing permanency with their biological parents or an adoptive family; too many children are separated unnecessarily from their families; and not enough services are available to meet the needs of the children and their families so that the children can be safely reunited with their families. The experts and others want change to the system, but the question then becomes "what programs effectively protect and improve the well-being of children and their families?"

The answer to this question lies in the approach used by experts to determine "effectiveness." In this Chapter, prior to looking at the effectiveness of California's child welfare system, we review terms and definitions that provide the basis for our assessment of the system.

MEASURING EFFECTIVENESS

Measuring program effectiveness or performance has received considerable attention in recent years, not only for social services programs such a child welfare services, but throughout all levels of government (i.e., federal, state, county and city) and across all publicly-funded programs. Recent action by the Congress sets the direction for performance measurement. In its Government Performance and Results Act (GPRA) of 1993, Congress directed all cabinet departments and other establishments of the federal government, including independent agencies, and Government corporations to submit strategic plans to Congress. Section 3 of the Act mandates that the plans contain "...general goals and objectives, including outcome-related goals and objectives.…"[28]

The Office of Management and Budgets (OMB) has the responsibility for carrying out the requirements of the Act and in a training document to aid in the development of strategic plans, OMB cites the following definitions as used in the GPRA:[29]

- ***outcome measure***: an assessment of the results of a program compared to its intended purpose.

[28] Executive Office of the President, Office of Management and Budgets, Circular No. A-11 Part 2 Preparation and Submission of Strategic Plans, June 1996, page 242.
[29] The Office of Management and Budgets, Primer on Performance Measurement, date unknown.

- ***output measure***: a tabulation, calculation, or recording of activity or effort that can be expressed in a quantitative or qualitative manner.

- ***impact measure***: a measure of the direct or indirect effects or consequences resulting from achieving program goals. An example of an impact is the comparison of actual program outcomes with estimates of the outcomes that would have occurred in the absence of the program.

- ***input measure***: a measure of what an agency or manager has available to carry out the program or activity; i.e., achieve an outcome or output. These can include: employees (FTE), funding, equipment or facilities, supplies on hand goods or services received, work processes or rules. When calculating efficiency, input is defined as the resources used.

The Center for the Study of Social Policy also developed definitions to help clarify terms which frequently are used interchangeably in discussions of program effectiveness. In a draft paper intended to help states and local governments shift to a new budgeting approach, the Center suggests the following definitions:[30]

- ***outcomes***: (also called "results" or "goals") conditions of well-being for children, families or communities. For example, "healthy children," "safe neighborhoods," "children ready for school," or "children succeeding in school." Outcomes are the fundamental desires of people and the fundamental purpose of government.

- ***indicators***: (also called "benchmarks" or "milestones") measures for which data are available to quantify the achievement of an outcome. For example, the rate of low birth weight babies helps measure achievement of healthy babies. However, a single data element usually fails to capture the full outcome. For example, another indicator of healthy babies may be whether children receive appropriate vaccination shots in a timely manner.

- ***performance measures***: (or "program measures") measures of the effectiveness of agency or program service delivery. These are measures of the system's production line and how well its services and programs are working or not working. For example, the rate of timely investigation of child abuse, or the number of applications for assistance processed on time.

[30] Center for the Study of Social Policy, From Outcomes to Budgets, An Approach to Outcome Based Budgeting for Family and Children's Services, July 1995, Draft, page 7.

OUTCOMES & OUTCOME INDICATORS

Because of current emphasis on program performance and accountability, several public and private agencies are developing, or have developed, outcome indicators for health and human service programs, including child welfare services. We found that Oregon and Minnesota were leaders among states in developing measurable goals to guide public policies and public expenditures. We also learned that other states, including Utah, Georgia, Iowa, Alabama, Arkansas, Kentucky, Missouri and New Mexico are working on statewide efforts in this area. At the local level, we learned that the El Paso County Welfare Department in Colorado has established outcome measures for its welfare programs and is currently using the measures to review and audit program achievements.

At the federal level, we found that the U.S. Department of Health and Human Services, Administration for Children and Families (ACF) has developed a preliminary set of social measures and national indicators for federal programs which address the needs of children and families, including child welfare programs. Further, through the Children's Bureau in the Administration on Children, Youth and Families, the ACF has proposed a review strategy aimed at improving state child welfare systems and improving outcomes for children and families. The strategy focuses on three broad domains which cover the continuum of child welfare services: safety, permanency, and child and family well-being.[31] However, most of the ACF's measures are process-oriented, not outcome-oriented.

In California, we learned about the County Welfare Directors Association's (CWDA) 1994 effort to develop outcomes measures. Based in part on "The Vision for Children in California" completed by the Child Welfare Strategic Planning Commission which articulated expectations for children and families, the CWDA recommended that outcomes should be designed "... to determine if California's children are reaching adulthood having experienced a safe, healthy, and nurturing environment, and whether CWS (child welfare services) are preventing further incidence of abuse, neglect, or exploitation of children receiving services."[32] The CWDA outcomes are:[33]

1. Families in which children are at risk of abuse and neglect, will remain together whenever possible without continued abuse and/or neglect.
2. Families and children for whom ongoing CWS intervention is initiated shall show improved functioning.

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[31] Children's Bureau, Administration on Children, Youth and Families, Administration for Children and Families, U.S. Department of Health and Human Services, Child and Family Services Review: State Self-Assessment, FY 1995 Pilot Version, draft as of September 1995.

[32] California County Welfare Directors Association, County Welfare Directors Association Statement on Outcome Indicators in Child Welfare Services, April 11, 1994, page 2.

[33] The CWDA has labeled its outcomes as "outcome indicators" although they attempt to measure "conditions of well-being for children and families." Using the definitions suggested by the OMB or the Center for the Study of Social Policy, we have chosen to label CWDA's measures 'outcomes' rather than 'outcome indicators.'

3. Children, when removed from the home, shall maintain family and community ties as appropriate.
4. Children in out-of-home care shall be in a safe and healthy living arrangement.
5. Children in out-of-home care shall achieve permanence as quickly as possible.
6. Children aging out of foster care shall be able to meet their basic needs.

Since the development of the outcomes in 1994, as an organization, CWDA has not taken any additional action on the measures. Rather, CWDA suggests individual counties to pursue implementation of the indicators at a county's initiative. During our visits to county children services agencies, however, we were told that while many counties agreed in principle with the CWDA's outcomes, most had not incorporated the outcomes into their county's program. Further, we found that few counties had adopted any outcomes or were collecting data to statistically measure the effectiveness of their programs.

In addition, we learned that through an interagency agreement with the University of California, Berkeley (UCB), Child Welfare Research Center, the California Department of Social Services has been collecting and analyzing data on child abuse and neglect, and out-of-home placement trends for the past several years. In particular, the Center has constructed a database that contains the foster care histories for more than 250,000 children who have been in out-of-home care since 1988.[34] With this information the Center has developed information on admission rates into foster care, the re-entry rates for children who were reunified, and the proportion of children who achieved permanemt placements within a fixed time frame.

While we recognize the value of the UCB data in providing useful information to the department and to the child welfare community as a whole, the data are not outcome oriented. Further, the department has no immediate plans to use the data as outcome measures for juding the effectiveness of California's child welfare system.

Nationwide, we found that private organizations are assisting public agencies in developing outcome measures. Based on independent research and policy direction, some organizations have proposed measures of performance and expected outcomes for child welfare programs. Principal among the private organizations are: the American Humane Association (AHA) and its National Center on Child Abuse and Neglect (NCCAN), the Center for the Study of Social Policy, and the American Public Welfare Association (APWA) and its affiliate the National Association of Public Child Welfare Administrators (NAPCWA). We also found that several private foundations provide funds to review and evaluate child welfare programs, including the Edna McConnell Clark Foundation, the W.K. Kellogg Foundation, the Annie E. Casey Foundation, the Stewart Foundation, the Lilly Endowment, the Carnegie Corporation and the Danforth Foundation.

[34] The Center published its most recent information in the publication: Performance Indicators For Child Welfare Services In California: 1995.

Advocates of outcome measures for child welfare programs frequently cited the cooperative effort of the AHA and the NAPCWA. These two organizations recognize the need for research on child welfare program that focuses on the consequences of children and family services and the absence of child welfare outcome indicators. Along with the Texas Department of Protective and Regulatory Services, these organizations co-sponsored the First Annual Roundtable on Outcome Measures in Child Welfare Services in San Antonio, Texas in March 1993. Because of the interest and support received at the First Roundtable from child welfare policy makers, program administrators and researchers, three additional roundtables have been held with the latest, The Fourth Annual Roundtable, held in San Antonio in May 1996.

The principal product evolving from the Roundtables is a set of matrices of outcome measures for child welfare programs. Based on preliminary work performed by staff from the organizations and a national planning committee created to work on the Roundtables, the matrices were developed around four target categories of outcomes: child safety, child functioning, family functioning and family continuity/preservation as follows:[35]

- Child Safety: Children are safe in biological homes, in out-of-home care, and as residents of the community.
- Child Functioning: Developmental needs are met. Education, training, and/or employment needs are met. Social, cultural, and identity needs are met. Behavioral, emotional, and health needs are met.
- Family Functioning: Developmental needs are met. Education, training, and/or employment needs are met. Social, cultural, and identity needs are met. Behavioral, emotional, and health needs are met. Environmental/housing needs are met.
- Family Continuity/Preservation: Children will reside safely in their own homes. When children cannot safely reside in their own homes, they will maintain stable, permanent family and kinship ties.

Within each target category, the matrices define the focus of change on the child, family and community. Based on input from the participants at the Roundtables along with outcomes used by state and local child welfare agencies across the nation, including the CWDA's proposed outcomes, the matrices incorporate indicators for each outcome category while recognizing the relationship among inputs, processes and outcomes. Appendix A contains a listing of the outcome indicators for each of the above-mentioned outcome categories.

Another collaborative effort between public and private agencies involves the Center for the Study of Social Policy and the States of Alabama, Arkansas, Kentucky, Missouri and New

[35] American Humane Association and National Association of Public Child Welfare Administrators, Matrices of Indicators Prepared for The Fourth Annual Roundtable On Outcome Measures In Child Welfare Services, May 16-18, 1996.

Mexico. Similar to the work by the AHA and the NAPCWA, the Center and the five states have attempted to identify child welfare program outcomes that are shared by all five states. The collaborative used the framework of defining outcomes focused around two areas: (1) improved outcomes for children and families already in the child welfare system or at high risk of entering the system; and (2) improved child welfare system.[36] Within the first area, the framework identified four categories of outcomes: child safety and health; child functioning; family functioning; and customer satisfaction. In the second area, the framework listed system inputs, system outputs and information system capabilities as the outcome categories. Appendix B contains the collaborative's preliminary outcomes for each focus area category. The information represents a compilation of outcomes suggested by the five states.

We agree with child welfare experts on the broad outcomes for children and families, such as child safety, and child and family well-being. However, because other service delivery systems can also impact these outcomes, we question whether any one agency, such as a children services agency, can be held accountable or claim credit for changes to conditions measured by the outcomes.

THE EFFECTIVENESS OF CALIFORNIA'S CHILD WELFARE SYSTEM

Using the definitions of outcomes and outcome indicators suggested in the previous section as a backdrop for our review, what can we say about the effectiveness of California's child welfare system? Briefly stated, little information is currently available to make a reasonable assessment about California's system. While we read and heard about information purporting to assess the system's effectiveness, we found little empirical evidence that could be used to make a reliable statement about the effectiveness of child welfare programs. Instead, most of the existing information about the State's system is process-related (i.e., assessing or describing the quantities or quality of services delivered), or information describing the child welfare population. Very little exists about the outcomes of the services. Also, we heard considerable anecdotal information about child welfare programs, some of it attesting to effectiveness. Others anecdotes implied that the system is ineffective and does not protect or improve the well-being of children and families served by the system.

Moreover, we found little consensus on more specific measurable outcomes for which the child welfare agencies should or could be held accountable. In addition, little agreement exists on which outcome indicators (i.e., data elements) can be used to measure achievement of an outcome. Also, except for data that some counties are collecting to measure the

[36] Center for the Study of Social Policy, State/Federal Collaborative For Comprehensive Child Welfare Information Systems Development Outcome Analysis, Draft, April 1995.

performance of selected county projects, little information is currently being collected on a statewide basis that would lend itself to indicators of outcome effectiveness. The absence of existing measurements essentially precludes any assessment about the system's effectiveness.

Although we were unable to determine whether California's child welfare system as a whole is effective, by looking at available data for some of the primary elements of the system, we can makes several comments and observations. With regard to the emergency response (ER) services, we note in Chapter 3 that California ranks significantly higher than the national average for the number of substantiated or indicated reports of abuse and neglect (18.3 per 1,000 children in the population compared to 14.8 for the national average, a difference of nearly 24 percent). However, as we also note in Chapter 3, because of the differences among states in definitions and policies, California's rank in these measures cannot be considered a reliable indicator of the effectiveness of the State's child welfare program in protecting children.

Some child welfare observers have suggested that the frequency with which children or families are reported to child protection services (CPS) multiple times without a protective action being taken might be a reasonable indicator of effectiveness of ER services. They suggest that if children are reported to CPS time after time without consequence, the ER system might be inappropriately screening out these reports. Currently, data tracking children reported but, not entering, the child welfare system are not collected by the State. We believe this is a shortcoming of the system.

In the foster care program, we note that a disproportionately large number of African American children enter the foster care system as compared to the ethnic group's percentage of the total California population under age 18 years (37 percent compared to less than 8 percent). Also, the number of children in foster care is growing at a faster rate in the past six years than the total California population under age 18 (39 percent compared to nearly 16 percent). When compared with 1994 data from other states, as shown in Chapter 3, California placed 56 percent more children in out-of-home care than the U.S. average (10.9 er 1,000 children in the State's population compared to 7.0 per 1,000 children in the U.S. population). In addition, when compared to the rate of growth in foster care to four other large states for the period 1983 to 1994, California had the second greatest increase at 163 percent. The combined five-state increase was 152 percent. However, when comparing the percentage of children leaving foster care within specified time periods, California performed better than two of four other states used in the comparison.

Although it is too soon to see any impacts resulting from the Governor's 1996 Adoptions Initiative, existing adoptions data strongly suggest that California's adoptions program was not effective over the past four or more years. As we showed in Chapter 1, the number of children adopted through the child welfare system increased by only six percent between 1989/90 and 1994/95 while the number of children in foster care increased by nearly 27

percent. Further, California's adoptive placement of foster children fell 15 percent between 1991/92 and 1994/95 (from 4,197 to 3,563 placements). During the same period the number of applications received for adoptions decline by nine percent (from 6,919 to 6,342). Also, approximately 85 percent of the placements were made by public agencies (either Department of Social Services District Offices or county welfare departments) and the remaining 15 percent were made by private agencies.

In Chapter 3, we compare California's 1994-95 foster care adoptions with ten other large states. We show that California ranks next to last in the number of adoptions per 100 children in foster care. The data show that California's placement rate was 3.5 per 100 foster care children compared to 17.9 for the State of Michigan. From discussions with staff in Michigan, more adoptive placement were made in that State by private agencies than by public agencies. For about 60 percent of its foster children adoptions, Michigan contracts with private agencies and, since April 1992, these contracts have included incentives to encourage speedier placements. Prior to that date, the payments to private agencies were usually based on actual costs which varied widely. In 1992, a three-tier structure of incentives was implemented, consisting of a "standard" payment of $3,500 for a placement within ten months from the date parental rights were terminated, an "enhanced" payment of $5,500 for a placement within eight months, and a "premium" payment of $8,000 for each placement made within five months.[37] As a result of implementing this incentive system, the number of placements by the private agencies increased from 910 in FY 1991/92 to 1,363 in FY 1995/96, an increase of almost 50 percent. During this same period, the number of public agency placements went from 770 to 826, an increase of seven percent. We also learned that in New York, a vigorous program emphasizing adoptions in New York City increased the State's placements by 30 percent between FY 1993/94 and FY 1994/95. According to representatives of New York's adoptions agency, this program required no additional resources to implement.

During our review, we heard comments from child welfare officials attempting to explain why California was not making more adoptive placements. These comments included: "adoptive families want young, healthy, Caucasian children" and "foster care children waiting for adoption are either too old or they have serious health problems because they are drug- or substance-exposed or HIV infected." Generally, data are not available to substantiate these comments. From the data in Chapter 1, we note that the ethnicity of adopted children is not significantly dissimilar to the total foster care population but younger children do appear to be more readily adopted than older children.

When considered as a whole, these adoptions data indicate to us that California's adoptions program can do better than it has been doing. As discussed in Chapter 1, through the Governor's Adoptions Initiative, the Department of Social Services has embarked on

[37] These rates are discrete; i.e., the enhanced or premium rate is not added to the standard rate. The rates as of October 1996 are $3,535 for "standard," $6,000 for "enhanced" and $8,600 for "premium."

significant reform of its adoptions program. However, it is too early to tell whether the initiative will produce results similar to those seen in Michigan and New York.

CONCLUSION

Based on available statewide information, little can be said at this time about the effectiveness of California's child welfare system as a whole. Much work remains to be performed in California before the effectiveness of the State's system can be measured using statistical data representing California' services. So that the State can begin to measure effectiveness of its child welfare services, we believe the Department of Social Services, the CWDA and county children services agencies should take the following actions.

We found that while child welfare officials are paying more attention to the need to measure the successes of child welfare programs, as a group, California's officials have not instituted efforts to measure effectiveness. Through the work of the California Welfare Directors Association (CWDA), these officials took the necessary first step in reaching consensus on articulating intended outcomes for children and their families receiving child welfare services. Now, CWDA, the Department of Social Services and local county children services agencies should take the next step: they should define and collect data on outcome indicators that can be used to measure achievement of the outcomes. To this end, with the full implementation of the new CWS/CMS system scheduled for December 1997, *we recommend that the department and CWDA immediately commence efforts to formally adopt outcomes for the child welfare system. Further, we recommend the department and CWDA identify outcome indicators, supported by data elements contained within the CWS/CMS system so that effective January 1, 1998 the department can begin collecting data to measure effectiveness of its child welfare system.*

When reviewing the program, we heard that children who are reported as abused and neglected but who do not enter the child welfare system often are re-reported at a later date for another incident of abuse or neglect. However, because counties and the State do not track this information, a child may be reported several times for different incidents of abuse or neglect before a serious enough incident occurs and the child enters CPS where his/her safety can be better ensured. Because data tracking these occurrences could be used to determine the effectiveness of the ER process, *we recommend that the department and CWDA specify recurrences of child maltreatment as an outcome indicator and track children who are reported as abused and neglected, even if no child protective services case is formally opened after the report.*

As we reviewed the adoptions program, we found that the department does not know how many children have a court approved permanent placement plan with adoptions as the goal. While the case plan goal may provide the department with some information, the department

does not know the reliability of the information. Consequently, w*e recommend that the department track the permanent placement plan goals for children whose permanent placement plan has been approved by the juvenile court*. In the absence of this information, the department cannot meaningfully measure the effectiveness of its adoption program. Further, this information will enable the department to set more realistic performance goals related to the Governor's Adoptions Initiative.

Data from the 1994/95 Community Colleges Foundation showed that only 13 percent of the eligible youths age 16 to 18 years in foster care received training through community college programs. We also heard anecdotal comments from child welfare officials suggesting that, overall, less than half of the eligible youths received any ILP services. In addition, some child welfare observers believe 40 to 50 percent of the youths who emancipate from foster care reportedly become homeless and/or who enter the adult criminal justice system. Therefore, *we recommend that the department and the counties enhance their efforts to provide independent living services to all youths eligible to receive ILP services who could benefit from such services*. Further, *we recommend that the department determine whether ILP services should be mandatory for all eligible youths rather than only provided to the youth who agree to the services.*

In the next Chapter, as another way of judging California's child welfare system, we compare California data on broad measures of performance with those of child welfare systems in other states.

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CHAPTER 3
NATIONAL CHILD WELFARE DATA

INTRODUCTION/SUMMARY.

At the national level, the major sources of information on child abuse and neglect are the National Center on Child Abuse and Neglect (NCCAN), and the Child Welfare League of America (CWLA). For California data on child abuse and neglect, information for 58 counties is assembled and analyzed by the Child Welfare Research Center (CWRC) at the University of California, Berkeley, under a contract with CDSS.

The major sources of information at the national level on foster care and adoptions assistance are the American Public Welfare Association (APWA) and the above-mentioned CWLA. The Chapin Hall Center for Children at the University of Chicago has assembled longitudinal data on foster care for five large states (including California) and one mid-size state. The Foster Care Information System (FCIS) operated by the CDSS provides the CWRC with county-level data on out-of-home placements. On the other hand, national data on adoptions only appears infrequently, the most recent available being for 1992 from the National Center for State Courts (NCSC).

Considerable care must be exercised when interstate comparisons of data are attempted. Every state uses its own definitions of child abuse and neglect and establishes its own criteria for substantiating child maltreatment. Some states count only cases of severe cases of abuse and neglect when reporting child maltreatment totals. Some states exclude cases of emotional abuse and medical neglect, and at least one state has excluded general neglect from its child maltreatment totals. Other states may include these but not consider lack of supervision sufficient to document a case of neglect. Consequently, the data collected by one state often does not correspond to data from another, despite the use of common terminology. Because of these differences, even the CWLA cautions the readers of its annual report on child maltreatment to avoid interpreting the relative number of reports of child maltreatment as a reflection of a state's effectiveness in protecting children.

To improve uniformity of data among states and to collect more reliable data on child welfare program indicators, the U.S. Department of Health and Human Services is now providing funding support for the states to establish automated data collection systems to serve as input for the Adoption and Foster Care Analysis and Reporting System (AFCARS). California is taking advantage of this funding to support its Child Welfare Services/Case Management System (CWS/CMS). However, it appears that an integral step towards outcome measurement, namely the development of performance standards, will not occur

until after December 1997, when the system is scheduled to be operational. As a consequence, currently it is very difficult to assess the performance of child welfare programs at either the State or national level.

Despite these shortcomings, we have examined the data from the above-noted sources and constructed graphic presentations comparing California with other states that have large populations of children. The data presented in this report will at least place California's child welfare data in a broader context and point to areas where further data collection and analysis are needed.

REPORTS OF CHILD ABUSE AND NEGLECT

Even prior to the passage of PL 96-272, the American Association for Protecting Children (AAPC), a division of the American Humane Association, was funded by the federal government to collect data on child abuse and neglect. In 1987, funding for this activity ceased; however, since 1982 this information has been collected by the National Committee for the Prevention of Child Abuse (NCPCA). The NCPCA conducts an annual voluntary survey of the states to monitor child abuse and neglect reporting trends. In 1990, amendments to PL 93-247 (the Child Abuse Prevention and Treatment Act) required the establishment of the National Child Abuse and Neglect Data System (NCANDS). States are now requested (not required) to submit their child abuse and neglect information annually to the newly established National Center on Child Abuse and Neglect (NCCAN), a part of the U.S. Department of Health and Human Services. Most researchers now use the NCANDS data for their analyses. The most recent year for which data are available is 1994.

The other major source of national information on child abuse and neglect is the document entitled, "Child Abuse and Neglect: A Look at the States," first published in 1993 (with 1991 data) by the Child Welfare League of America. This publication brings together child welfare information, mostly from the NCCAN and occasionally the CWLA's own surveys. The latest document, published in 1995, generally includes data for 1993.

According to NCCAN estimates, in 1994 the number of persons under 18 in the United States was a little more than 68 million, as compared to 62.6 million in 1984. For comparisons with California, however, we have found it more useful to focus on the twelve states with the greatest populations of children. These twelve states account for almost sixty percent of the national total of children and we display this group, together with the high- and low-ranking states and the U.S. average, in most of our graphic presentations. Figure 3-1 displays the twelve largest states ranked by the size of their under 18 populations in 1994. California ranks as the highest with 8.68 million and Virginia the lowest of these states at 1.60 million.[38]

[38] For all figures appearing in this chapter, the data and their source appear in Appendix C.

FIGURE 3-1
TWELVE STATES WITH THE GREATEST POPULATIONS OF CHILDREN IN 1994
Estimated Number in Millions

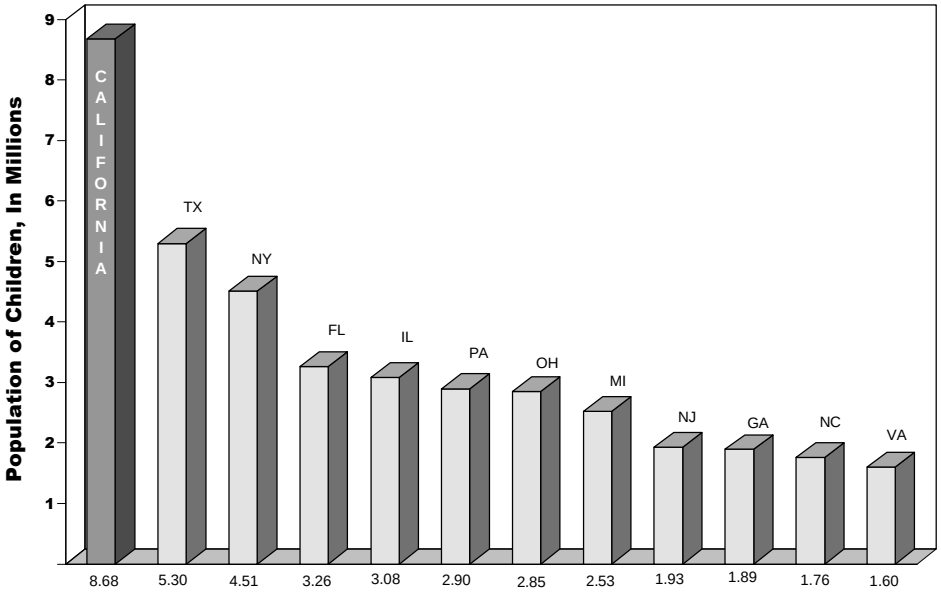
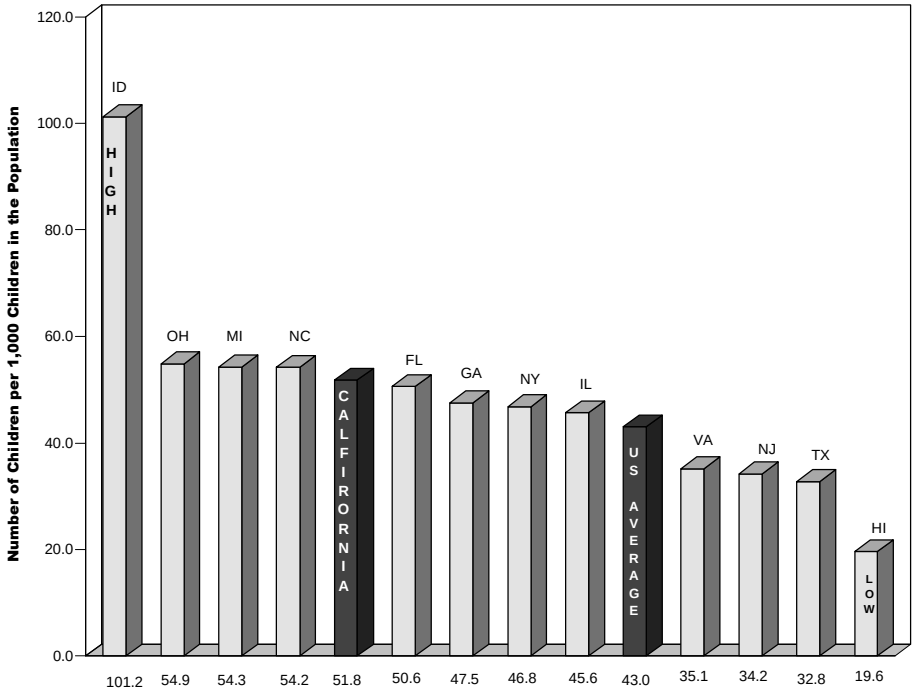


FIGURE 3-2
CHILDREN REPORTED AS ABUSED AND NEGLECTED IN 1994
Per 1,000 Children in the Population



Based on data collected from fifty states, the NCCAN information shows a national total of 2.9 million children were involved in reports of abuse or neglect that were investigated by state children services agencies in 1994. Figure 3-2 shows the number of reports per 1,000 children in the population for the states with the largest population of children and for the states with the highest and lowest report ratios.[39] Idaho ranks the highest, with 101.2 reports per 1,000 children, and Hawaii as the lowest, with 19.6. The U.S. average is shown to be 43.0 and California ranks fourth among the largest states with 51.8. The total of 449,177 children reported for California by NCCAN represents an accounting that is readily compared to other states. On the other hand, the most commonly published workload statistic published by the CWRC for California is 664,294 child abuse reports for the same reported year, 1994. The difference between the numbers reflects the 215,717 emergency responses screened out (i.e., not investigated) by county children's services agencies.

Again, because of differences among states in definitions and methods of reporting data, it is important not to interpret California's rank in reports of abuse and neglect as an indication of the effectiveness of its child welfare system. In fact, California's high number of reports may simply reflect the State's doing a better job than other states of informing doctors, nurses, teachers, and others subject to mandatory reporting laws of their statutory obligations.

According to NCPCA's 1994 data, the number of investigated reports of child maltreatment nationwide has increased 63% since 1985.[40] In California, the number of total reports (we do not have data on investigated reports for 1985) has increased 124 percent during the same period.

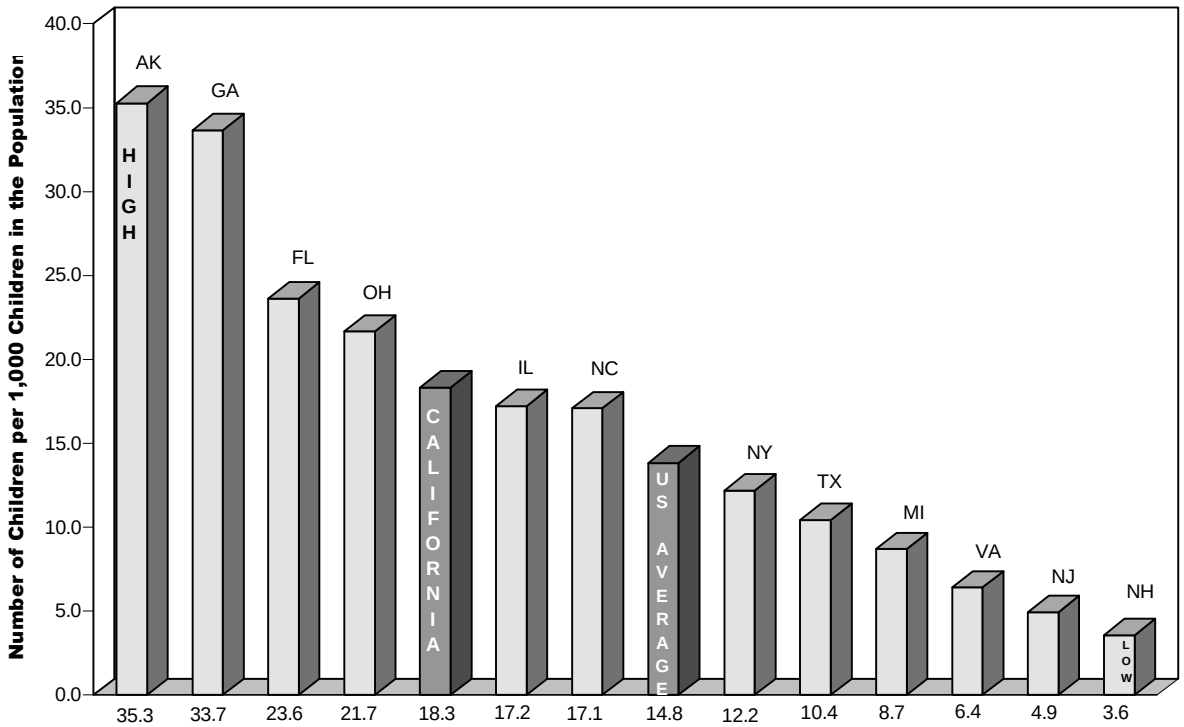
Because not all reports of child maltreatment turn out to be substantiated, a more valid indicator of performance is the number of children with substantiated or indicated reports. Figure 3-3 displays such information for 1994 gathered from 47 states with a total of more than one million children for whom emergency response dispositions were reported to NCCAN. The highest ranking goes to Alaska, with 35.3 substantiated reports per 1,000 children; New Hampshire is lowest at 3.6; and the national average is 14.8. California ranks fourth among the largest states at 18.3, a little above the national average.

One limitation worthy of note when examining Figure 3-3 is that 37 states have a two-tier system in which a child abuse report is "substantiated" or "unsubstantiated." The remaining 13 states additionally include a third tier for "indicated," where substantiation was not achieved but reasons were found to suspect child abuse or neglect. Additionally, some states

[39] In Figure 3-2 and subsequent graphic presentations, we have removed Pennsylvania from the group of largest states compared since that state screens out cases of neglect that are counted by other states. As of July 1995, however, Pennsylvania is reported to have adopted definitions closer to those other states. See Curtis, P.A., Boyd, J.D., and Petit, M., Child Abuse and Neglect: A Look at the States, Washington, D.C.: Child Welfare League of America, 1995, p. 7.

[40] Curtis, et al., ibid., p. 6.

FIGURE 3-3
NUMBER OF SUBSTANTIATED OR INDICATED REPORTS OF ABUSE AND NEGLECT, 1994
Per 1,000 Children in the Population



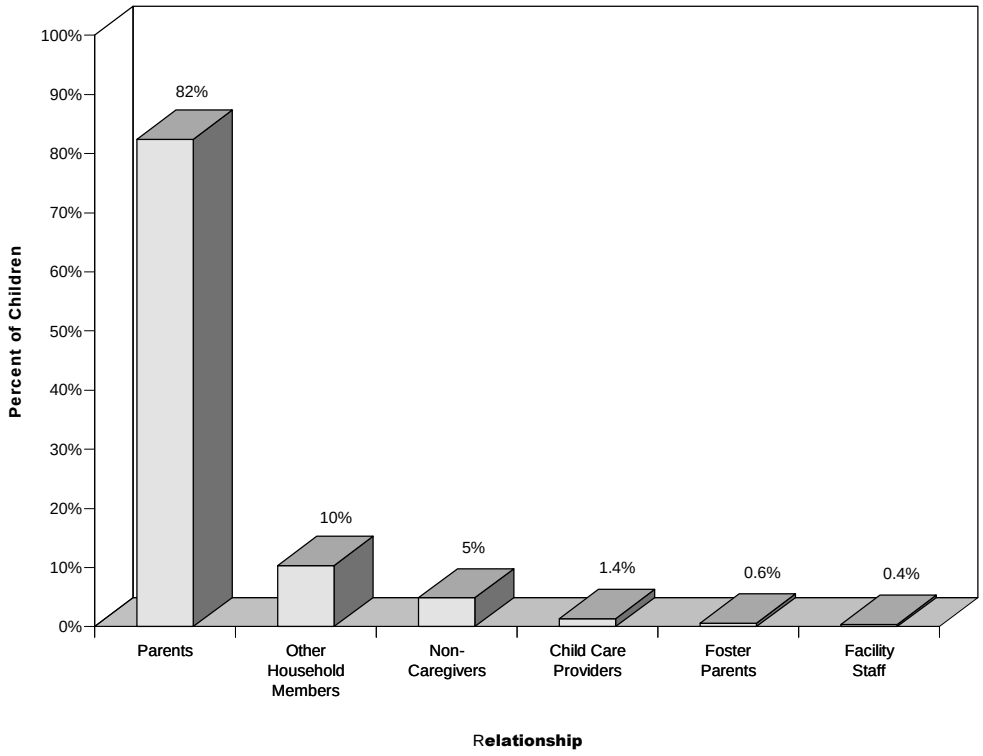
screen out reports without an investigation being conducted, others follow up on every report with an interview. Some states include "emotional abuse" and "medical neglect" in their totals; others only report "general neglect," "physical abuse" and "sexual abuse."[41]

An example as to how such data can be misleading is the fact that Alaska ranks the highest in Figure 3-3, but that state includes children with reports that have neither been "substantiated" nor "indicated" in its totals. It is also important to note that neither the number of substantiated and indicated reports per 1,000 children in the population nor the rate of growth in those reports should be taken as a reflection of a state's effectiveness in protecting children. The number of reports of child maltreatment is affected by many factors, e.g., local and statewide publicity about child maltreatment and state reporting laws and policies. Furthermore, substantiation of child maltreatment varies according to state and local policies, including those set by the courts, regarding the documentation needed to substantiate abuse or neglect.

[41] Ibid., p. 3.

The attention of public officials is often drawn to the perpetrators of child abuse, particularly when the news media focuses on cases involving child care providers or foster parents. Figure 3-4 shows that such cases are rare, with by far the greatest number of perpetrators (82%) being parents. Another 10% of cases of abuse or neglect are caused by other household members. Child care providers, foster parents and facility staff account for less than 2% of the cases.

FIGURE 3-4
RELATIONSHIP OF OFFENDERS TO CHILDREN WHO WERE ABUSED AND NEGLECTED, 1994



FOSTER CARE

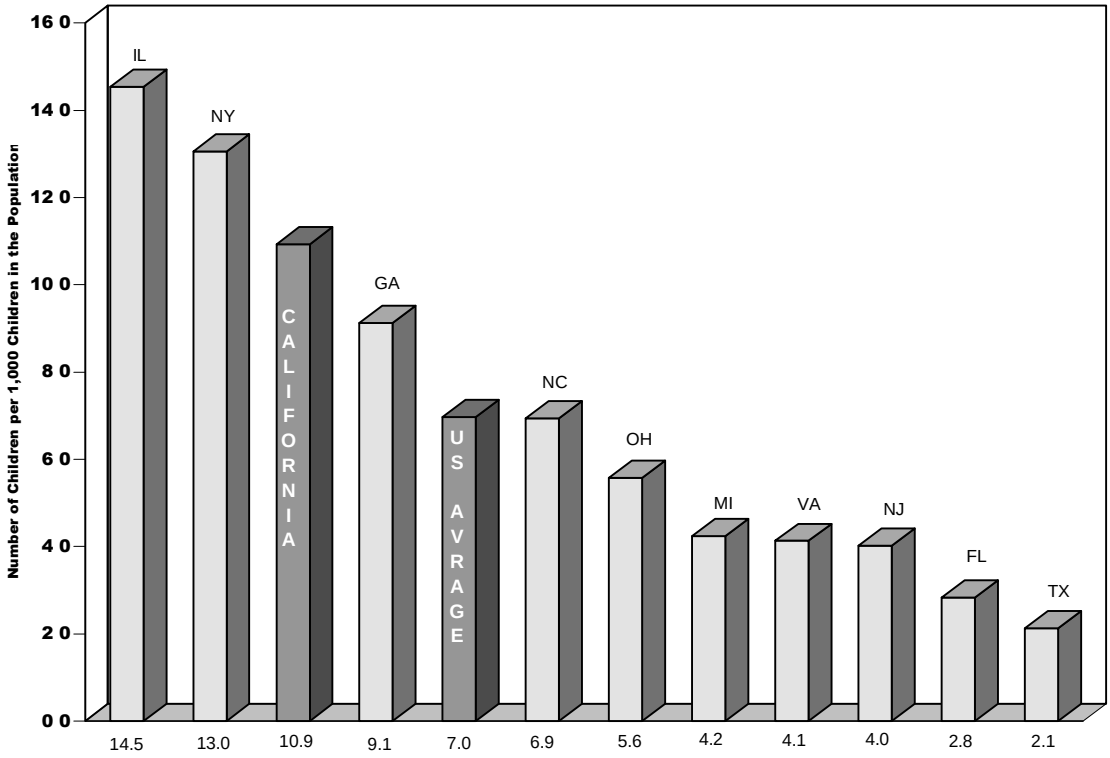
The major source of national information on children in out-of-home care is the Voluntary Cooperative Information System (VCIS), operated by the American Public Welfare Association (APWA). The U.S. Department of Health and Human Services has been supporting this voluntary survey since 1982. The VCIS data pertain to children in "substitute care" under the management and responsibility of the state children services agencies, including foster care (kinship and non-kinship); group homes; child care facilities; emergency shelter care; supervised independent living; non-finalized adoption placement; and any other 24-hour arrangement considered as substitute care by the state. The CWLA Stat Book (previously mentioned in the discussion on data sources for information on child abuse and neglect) makes much use of the VCIS data for its own analyses of children in out-of-home care. Most of the VCIS data are based on state fiscal years (which can vary by state);

however, some information is also available by calendar year. The most recent data available from VCIS are for 1994.

Some persons believe that the rate at which children are removed from their homes is a valid indicator of the performance of the child welfare system. However, the rate of removal can be considered an indication of success or failure, depending on the interpretation of the reviewer. On the one hand, it can be interpreted as the level at which children are being protected by removal from a hostile environment, a measure of success. On the other hand, this same rate can be interpreted as the degree of failure of the child welfare system to provide services that would allow children to remain safely at home.

All 50 states provided data for VCIS on the number of children in out-of-home care in 1994. According to VCIS data, the national total for the number of children in out-of-home care was 464,077 in 1993, compared to 400,431 in 1990. Figure 3-5 shows the state rankings in children placed in out-of-home care as of December 31, 1994, per 1,000 children in the population. Illinois ranks the highest with a rate of 14.5 per 1,000 children in their population. Texas ranks the lowest in the nation with 2.1. However, this amount is not comparable with the amounts from other states because, unlike most other states, Texas does

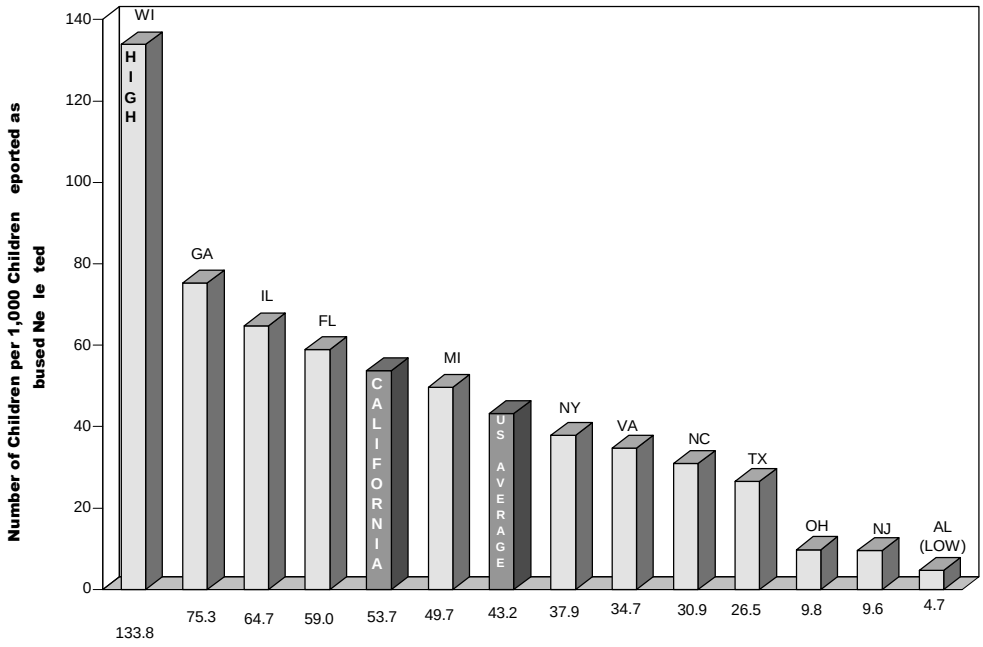
FIGURE 3-5
CHILDREN IN OUT-OF-HOME CARE, AS OF DECEMBER 31, 1994
Per 1,000 Children in the Population



not include out-of-home placements with kin as foster care placements. California ranks third among the large states at 10.9, considerably higher than the national average of 7.0. These differences in placement rates between states may reflect many factors, including differences in resource allocations, policies and practices regarding investigations and willingness to remove children from their homes. It may also reflect differences in definitions, e.g., whether placement of children with kin is considered a foster care placement under all circumstances. Information about these factors for the various states is unknown.

It is also useful to look at the number of children removed from their homes in a recent year. Figure 3-6 shows the state rankings for 1994. We have elected to show the number of children removed as a percentage of the children who are reported as abused or neglected in the same year. The NCCAN data were based on a reported 126,117 children in 35 states who were removed from their homes during 1994. Highest ranking is for Wisconsin, at 133.8 children removed per 1,000 reported as abused and neglected; lowest ranking goes to Alabama with 4.7; and the national average is 43.2. California ranks fourth among the large states at 53.7, about 25 percent higher than the national average. These differences reflect both the differences noted in the above paragraph and differences in reporting laws and practices among the states. In addition, California's figure represents only the number of

FIGURE 3-6
CHILDREN REMOVED FROM THEIR HOMES, 1994
PER 1,000 CHILDREN REPORTED AS ABUSED AND NEGLECTED



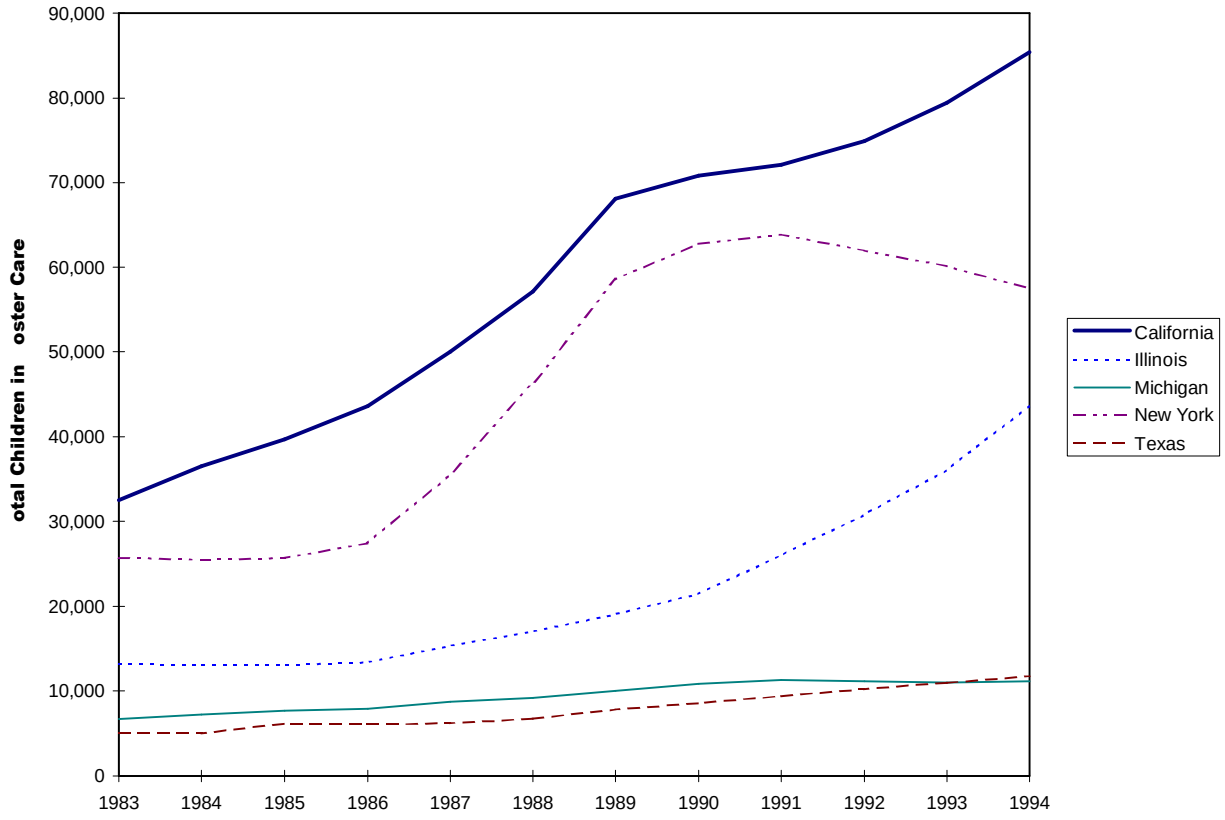
children removed involuntarily from their homes by children's services agencies; it excludes about 5,000 children removed from their homes by probation departments and another 2,000 children removed voluntarily or for what the Department of Social Services describes as "services only." We do not know whether the data for other states similarly exclude these placements. Consequently, we cannot say that the figure represents an accurate comparison across states. If the excluded children had been included in California's total reported to NCCAN, California's ratio in Figure 3-6 would have been 76.1.

Another source of information on foster care in several large states is the Multi-State Foster Care Data Archive (supported by a grant from the U.S. Department of Health and Human Services), and maintained by the Chapin Hall Center for Children at the University of Chicago. The latest published version of the data from Chapin Hall covers the years 1983-1992 for five large states, namely California, Illinois, Michigan, New York and Texas. The latest unpublished data obtained by DOF from Chapin Hall, cover six states (including Missouri) and the period 1983-1994.

The data for the Archive are extracted from the administrative data systems of each state's child welfare agency. Important attributes of these data are that they are longitudinal in nature and quite comprehensive. The major focus of Chapin Hall's studies relates to changes over time in the number and characteristics of children admitted to, and discharged from, foster care; the comparative risk of a children being placed; and the amount of time children spend in foster care. The structure of the Archive's data base permits the researchers to examine each child's foster care experience over time. At least for the six participating states, a detailed and reasonably reliable account of foster care dynamics can be examined. In our presentation below, we have excluded data for Missouri because of the the uncertain quality of the data for that state and because the state's population of foster care children is so much smaller than that of the other states.

As noted earlier, a census of children in out-of-home care on a given day is the most common indicator used to examine changes. Figure 3-7 presents this information for the five major states for the caseload on December 31 for the years 1983 through 1994. According to the Chapin Hall data, there were 209,459 children in foster homes in the five states on December 31, 1994. These children represent almost half of the nation's total. This five-state population of children in foster care is more than two-and-a-half times the 83,124 counted at December 31, 1983. Across the five states, most of the rapid growth shown in Figure 3-7 appears to have occurred in the period between the end of 1986 and the end of 1989. The five states' foster care totals increased by more than 66 percent during that three-year time span, producing an average yearly growth rate in excess of 18 percent. In contrast, the data show an increase of only about six percent from the end of 1993 to the end of 1994.

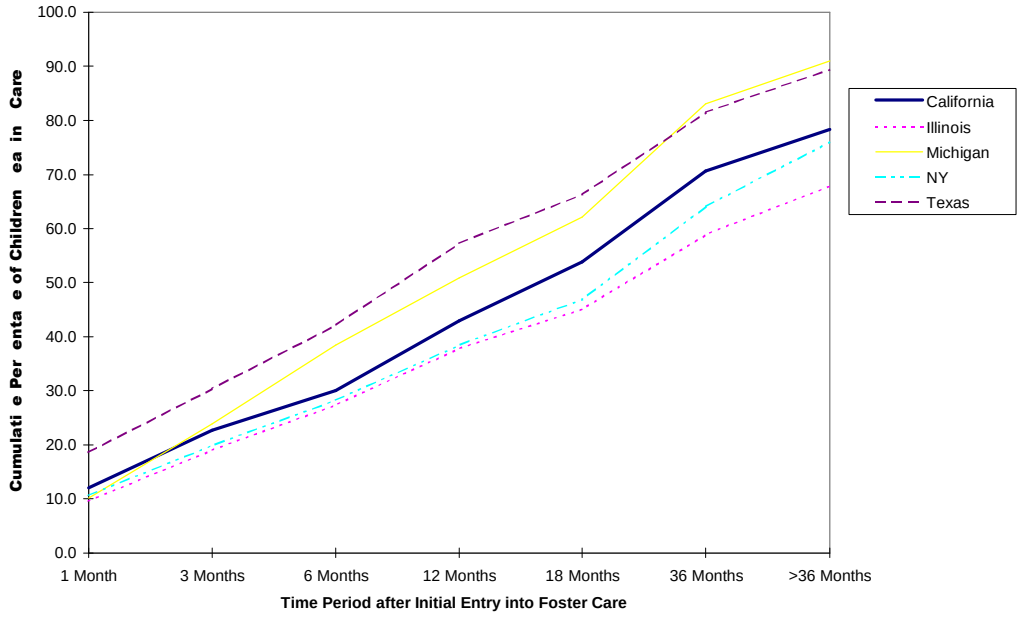
FIGURE 3-7
FOSTER CARE CENSUS FOR CALIFORNIA AND FOUR OTHER STATES
1983-1994



Once again, caveats regarding the data for interstate comparisons are in order. Some states include non-Title IV-E children in their counts while other states do not; some states include children under supervision of probation departments while others do not; some states (Texas is an example) exclude placements with kin from their foster care totals; "placement spells" can vary by state; and the existence of interstate placements provides the potential for some double-counting.

The length of time children spend in foster care can also be a good indicator of how well the child welfare system is working. Based on the 1992 Chapin Hall data, Figure 3-8 displays graphically (for California, Illinois, Michigan, New York and Texas) the percentage of children leaving foster care within specified time periods. The data in this chart is for children who entered the foster care system in 1990.

FIGURE 3-8
PERCENTAGE OF CHILDREN LEAVING FOSTER CARE WITHIN SPECIFIED TIME PERIODS FOR CHILDREN ENTERING FOSTER CARE IN 1990



As indicated by Figure 3-8, for all states, most children admitted to foster care exit within 36 months after being admitted. However, some states seem to do a better job than others in returning children home and in returning them home rapidly. California ranks in the middle of the five large states in both respects. However, comparing states in these respects is difficult because we do not know (even for California) the severity of the abuse and neglect or the degree of family problems that led to removal in any state. In addition, although we know that approximately 20 percent of the foster children returned home in California re-enter foster care within three years of first exit, we do not have comparable data for other states.[42] Some states may be jeopardizing the safety or well-being of children by returning them home too quickly. Without knowledge of "re-entries" and information about the characteristics of the foster children and their families for each state, nationwide comparisons are not very meaningful.

Another difference among states that must be considered is the state's use of kinship care, i.e., the placement of children with relatives. As indicated in Chapter 1, we heard from many experts that children placed with kin spend longer periods of time in foster care than those placed with non-kin. Therefore, in making nationwide comparisons on the length of time a

[42] Child Welfare Research Center, Performance Indicators for Child Welfare Services in California: 1995, Sacramento, CA: California Department of Social Services, unpublished, 1997, p. 114. The latest CWRC data for which foster care exits have been tracked for at least 36 months cover children discharged to parents or guardians between 1989 and 1992.

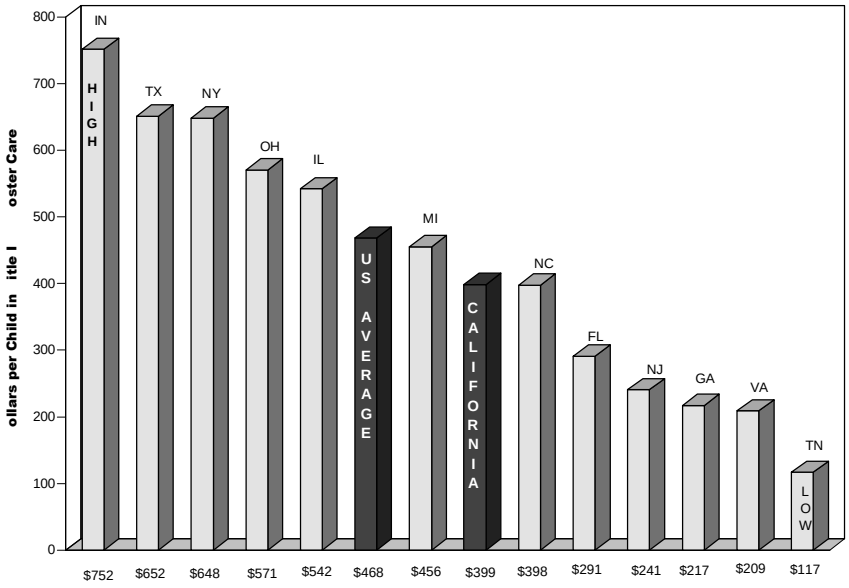
state's children spend in foster care, it is important to compare the same states' use of kinship care. Little reliable national data are available to document such a trend, but the Office of the Inspector General of the Department of Health and Human Services reported in 1992 that in 25 states that tracked such placements, kinship placements increased from 18 percent to 31 percent of the foster care caseload during the four-year period from 1986 to 1990.[43] Consequently, the need for data on kinship placements is becoming more important for meaningful analysis of nationwide data.

FOSTER CARE MAINTENANCE PAYMENTS

In 1994, the U.S. Congress appropriated $2.6 billion for Title IV-E expenditures, of which 50 percent was for foster care maintenance payments. A state's share of the monthly foster care maintenance payment is set at that state's Medicaid match rate, which ranged from 50 percent to 73.85 percent in 1994.[44]

Based on data from 50 states, Figure 3-9 shows that Indiana with a rate of $752 per child has the highest monthly average rate of all states. The state with the lowest rate is Tennessee with $117 per child. The national average for 1993 was $468. Among the large states, California ranked sixth with an average of $399.

FIGURE 3-9
FOSTER CARE MAINTENANCE PAYMENTS UNDER TITLE IV-E, 1993
Per-Child Monthly Averages



[43] U.S. Congress, Ways and Means Committee, 1994 Green Book: Overview of Entitlement Programs, Washington, D.C.: U.S. Government Printing Office, 1994, Section 14, p. 1.
[44] Ibid., p. 47.

ADOPTIONS

As mentioned previously, state-by-state information on adoptions is difficult to obtain. Only twice in the last ten years has the federal government funded such data collection. Each time, for 1987 and 1992, the data were collected by the National Center for State Courts (NCSC). Based on information provided by 50 states, the NCSC reported a total of 125,248 children being adopted in the United States in 1992, as compared with 118,216 in 1987.

Our analysis of the NCSC data, however, revealed a major problem, namely that the numbers presented are for total adoptions, of which the number of children under public agency care represents only a small portion. The majority of adoptions are step-family adoptions. These, as well as foreign adoptions, are not the responsibility of children services agencies. Moreover, the NCSC's data for California adoptions are estimates of unknown validity. Because the Department of Social Services provided data to the NCSC only for public agency adoptions, the NCSC inflated the California data by using the ratios for the non-public agency children in other large states in order to come up with an estimate of total adoptions in California.

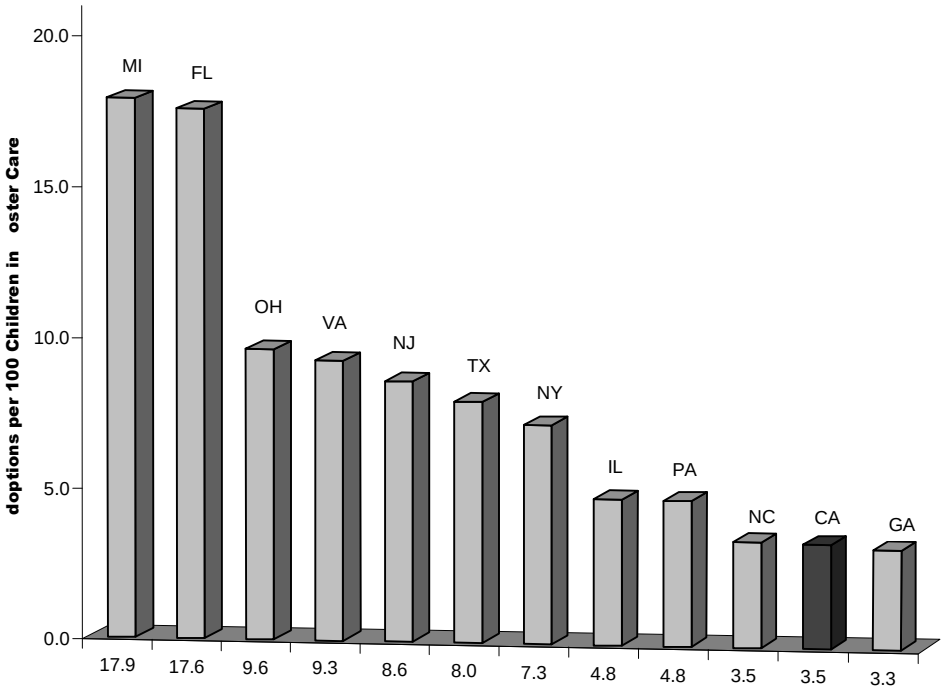
A more important indicator for child welfare programs, however, is the number of children under public agency care that are placed in adoptive homes.[45] We phoned several large states to obtain this data for at least three fiscal years. The latest year for which we have data for eleven large states, including California, is 1994/95. The results of our survey are displayed in Figure 3-10, which shows the number of adoptions per 100 children in foster care as of the end of the prior year. As can be seen in Figure 3-10, California, with 3.5 adoptions per 100 children in foster care, ranks low in this statistic. Michigan and Florida, with 17.9 and 17.6 adoptions per 100 children in foster care, rank at the high end. Several states (Ohio, Virginia, New Jersey, Texas and New York) produce between 7.3 and 9.6 adoptions per 100 children in foster care. Although the usual qualifications about the limitations of the data apply to these amounts, the magnitude of the difference between California's adoption totals and those of several other states suggests that California has room for improvement in this area.

INADEQUACY OF DATA AND IMPROVEMENTS NEEDED

Making valid comparisons between states using national data can be very difficult because not all states respond to voluntary survey requests. To make matters worse. policies, methods, definitions and collection systems differ among states. Even with the data collected, we have noted many problems documented in previous pages. Greater uniformity

[45] These figures include children placed in adoptive homes by private adoption agencies. Several states contract with private adoption agencies to place children for which the state is responsible. Michigan, for example, contracts with private adoption agencies for about 60 percent of its placements.

FIGURE 3-10
ADOPTIONS OF CHILDREN UNDER PUBLIC AGENCY CARE, 1994/95
Per 100 Children in Foster Care



and mandated collection tied to funding is probably needed before a clear picture can be drawn of how the states are performing with respect to child welfare programs. The Chapin Hall Archive is a step in the right direction, but more data, such as that being collected by CWRC for California, needs to be collected by other states. Moreover, additional data on characteristics of the children placed in foster care, and on their families, and for adopted children need to be collected and analyzed before we can have some assurance that data are comparable from state to state. An even if such data were available, there is a need for a thorough analysis of differences among states in policies regarding reports of abuse and neglect, investigation and substantiation of those reports, and placement in out-of-home care versus providing services to minimize out-of-home care before we can use data for other states in measuring the performance of California's child welfare system.

As a means to alleviate some of the differences between states' collections of child welfare data, in 1993 the U.S. Congress passed an amendment to the Title IV-E as part of the Omnibus Budget Reconciliation Act (PL 103-66). This amendment authorizes an enhanced Federal matching rate to states to cover costs related to a new national data collection system. The new system is the Adoption and Foster Care Analysis and Reporting System (AFCARS) and will be organized and operated by the U.S. Department of Health and Human Services. In order to qualify for the enhanced 75 percent Federal match, a state collection system must include data on child welfare services, foster care and adoptive services, family preservation and support services, and independent living.

To meet the AFCARS requirements, the state system must do the following:

- "Provide for electronic data exchange, within the State, with data collection systems operated under AFDC, Medicaid, child support enforcement and the National Child Abuse and Neglect Data System (unless not practicable for certain reasons);
- Provide for automated data collection on all children in foster care under the responsibility of the State child welfare agency, to support implementation of Section 427 protections and requirements;
- Collect and manage information necessary to facilitate delivery of child welfare services, family preservation and family support services, family reunification services, and permanent placement;
- Collect and manage information necessary to determine eligibility for the foster care, adoption assistance and independent living programs;
- Support necessary case management requirements;
- Monitor case plan development, payment authorization and issuance, review and management including eligibility determinations and re-determinations; and
- Ensure confidentiality and security of information in the system."[46]

Under AFCARS rules, in addition to collecting case-specific data on foster care children, states will be required to collect data on all adopted children placed by the state child welfare agency. States will report their data twice a year. Although set to expire on September 30, 1995, the enhanced funding for the states has since been extended to September 30, 1997 as part of recently enacted federal welfare reform.

California is taking advantage of the federal funding to support its Child Welfare Services/Case Management System (CWS/CMS). However, it appears that an integral step towards outcome measurement, namely the development of performance standards will not be developed until after December 1997 when the system is scheduled to be operational. As a consequence, currently it remains very difficult to assess the performance of child welfare

[46] Ibid., p 63.

programs at either the state or the national level. Hopefully, when the CWS/CMS system is complete, and other states have completed the implementation of their systems, data similar to those presented in this report will be more consistent from state to state and allow meaningful comparisons. But states ultimately will have to turn their attention to important outcome measures if there is to be any meaningful evaluation of the effectiveness of child welfare programs.

CHAPTER 4
FAMILY PRESERVATION PROGRAM

INTRODUCTION

Family preservation and support services are intended to minimize placements in foster care by providing appropriate services to families involved in substantiated cases of child abuse or neglect. Family preservation became national policy with the enactment of the Adoption Assistance and Child Welfare Act of 1980 (PL 96-272), the law that forms the basis for the State's current child welfare program.

Although there was a promise of federal funds for family preservation services, the promised funds have only recently been appropriated. Consequently, family preservation programs initially were implemented primarily through local, state and private funds. Among the early leaders in the family preservation movement was the Edna McConnell Clark Foundation, which provided funds to many local welfare agencies to implement a specific model of intensive family preservation services developed by Homebuilders in Tacoma, Washington. Under that model, social workers make frequent visits to families in their homes and are available 24 hours a day, seven days a week for crises that may arise. Under the Homebuilders model, social workers attempt to teach various coping skills and child development skills to family members and help them obtain other necessary resources and services, including food, clothing shelter, and counseling. The services are provided over a period of five or six weeks and only to families in which there is imminent risk of a child's being placed in foster care. The workers providing the services have caseloads of no more than two families per worker.

During the late 1970's and 1980's, the Homebuilders model and similar models of "intensive family preservation services" for families with children at imminent risk of placement eventually were adopted by several children services agencies. Until recently intensive family preservation models have been the primary focus of the child welfare community. This has been due in large part to the early reports of program success and to the ready source of funds for such programs from the Edna McConnell Clark and Annie E. Casey Foundations. Consequently, the majority of the research conducted on family preservation and support programs is based upon the intensive family preservation services model.

Many other types of family preservation programs have begun to be implemented since the federal government began appropriating funds for the Family Preservation and Family Support Program, which was created through the 1993 federal budget.[47] This should be kept in mind in assessing the research summarized below, most of which is based on the "intensive services" model. We have reviewed only studies that employed either an experimental design involving randomly-assigned treatment groups (i.e., families receiving family preservation services) and control groups (families receiving no services or a less intensive form of services) or a quasi-experimental design, in which assignment to treatment and control groups was not random but an attempt was made to control for differences between the two groups. A more thorough discussion and review of this research can be found in Appendix D.

SUMMARY OF FAMILY PRESERVATION PROGRAM RESEARCH

Early research on family preservation services cited dramatic reductions in the percentage of child abuse and neglect cases requiring removal of children from their homes. Much of this research focused on the Homebuilders program. For example, Kinney, et al., found that 97 percent of the 3,500 cases served by Homebuilders in the State of Washington between 1974 and 1987 had avoided placement in out-of-home care three months after having received intensive family preservation services. The authors also found that 88 percent of the cases served since 1982 still had avoided placement twelve months after treatment.[48] For a group of Washington families served by Homebuilders between 1985 and 1987, Pecora, et al., found that 94 percent of the families avoided placement at three months after treatment and 70 percent avoided placement at 12 months after treatment.[49] Similar results were found for the Homebuilders model when it was implemented in Florida[50], and less encouraging, but positive, results were found in Utah.[51] However, results for other types of intensive family preservation services programs operating before 1980 were mixed.[52]

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[47] The federal Family Preservation and Family Support Program was created by Congress as part of the Omnibus Budget Reconciliation Act of 1993 (PL 103-66). Congress has since appropriated funds to state and local child welfare agencies through September 1998 for implementation of the program.

[48] Kinney, J., Haapala, D., Booth, C., and Leavitt, S., "The Homebuilders Model," in Whittaker, J., Kinney, J., Tracy, E. and Booth, C. (eds.), Reaching High-Risk Families: Intensive Family Preservation in Human Services, New York: Aldine de Gruyter, 1990. It should be noted, however, that, contrary to common practice today, the 97 percent and 88 percent figures exclude children placed in kinship care. See Pecora, P., Fraser, M., and Haapala, D., "Client Outcomes and Issues for Program Design," in Wells, K. and Biegel, D.E. (eds.), Family Preservation Services: Research and Evaluation, Newbury Park, CA: Sage Publications, 1991, p. 18.

[49] Pecora, et al., ibid. (note 2), pp. 18-19.

[50] Paschal, J., and Schwahn, L., "Intensive Counseling in Florida," Children Today, 15, November/December 1986, pp. 12-16.

[51] Callister, J., Mitchell, L., and Tolley, G., "Profiling Family Preservation Efforts in Utah," Children Today, 15, November/December 1986, pp. 23-25 and 36-37. Also see Pecora, et al., op. cit., pp. 18-19.

[52] Summaries of research on many of these programs are contained in Frankel, H., "Family-Centered, Home-Based Services in Child Protection: A Review of the Research," Social Service Review, March 1988, pp. 137-157; Littell, J.H. and Schuerman, J.R., A Synthesis of Research on Family Preservation and Family Reunification Programs, Rockville, MD: Westat, Inc., May 1995; and Stein, T., "Projects to Prevent Out-of-Home Placement," Children and Youth Services Review, 7, 1985, pp. 109-121.

Since 1990, several researchers have reexamined intensive family preservation services programs and have questioned the reliability of the early research findings.[53] Among other things, these researchers noted that the early family preservation research did not employ control groups or used samples that were not randomly selected, and many of the studies involved sample sizes that were too small or narrowly focused to provide meaningful information. Some researchers have observed that most early studies provided little information on how families served by the programs were doing two or more years after treatment. They note that where follow-up information is available, the percentage of children served by the programs who are placed in foster care tends to be much higher than cited by the studies.

These concerns have led several recent family preservation evaluations to larger sample sizes and randomly selected control groups. The results of those studies cast doubt on the effectiveness of intensive family preservation services. In four of the largest controlled studies of intensive family preservation services, only one of the four studies showed a positive impact on placement rates. Two of the studies showed a negative impact on placement rates and the other showed no impact.[54]

Some of the early researchers and promoters of intensive family preservation services models have been highly critical of this recent research.[55] In particular, they cite methodological problems associated with the research designs and program implementation of the family preservation research that questions the effectiveness of the program. They note, for example, that the researchers inappropriately used data for heterogeneous groups in testing the effectiveness of the model. According to the critics, recent studies have shown that *some* groups receiving intensive family preservation services have positive outcomes even if the program does not appear to be effective for all families treated. The critics also cite implementation problems in the states in which recent family preservation research has been conducted. They note that the family preservation services provided to families varied widely even within specific states (California is cited as an example), that widely varying policies and philosophies of state and local child welfare agencies dictated which families

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[53] In 1991 and 1992, under a grant from the Edna McConnell Clark Foundation, Peter H. Rossi evaluated the latest major research projects and found that they do not provide conclusive findings about the effectiveness of family preservation services. A similar conclusion was drawn by Wells and Biegel who reviewed the same research projects and published their findings in a 1992 article. See Rossi, P. H., Evaluating Family Preservation Programs: A Report to the Edna McConnell Clark Foundation, New York: The Edna McConnell Clark Foundation, August 1991; Rossi, P. H., "Assessing Family Preservation Programs," Children and Youth Services Review, 14, 1992, pp. 77-97; and Wells, K. and Biegel, D.E., "Intensive Family Preservation Services Research: Current Status and Future Agenda," Social Work Research and Abstracts, 28(1), 1992, pp. 21-27.

[54] See Appendix D**,** for details on those studies.

[55] These criticisms are summarized in Bath, H. and Haapala, D., "Family Preservation Services: What Does the Outcome Research *Really* Tell Us?," Social Service Review, September 1994, pp. 386-404.

and children received the services, that most families receiving the service did not meet the strict eligibility requirements, i.e., having children who were "at imminent risk of being removed from their homes," and that welfare workers can and do subvert the research designs of pilot projects by altering the manner in which they make recommendations. The critics also cite problems with the outcome measure used to assess program effectiveness, i.e., reduced placements in foster care. According to the critics, other family preservation program outcomes are important, and placement in foster care is an appropriate outcome in many cases. Among the other outcomes thought to be important are "family functioning," "family environment," and "child well-being."

The researchers have countered with arguments defending their evaluations. They also have noted that while they agree with their critics that placement in foster care is not the only, or even the best, measure of the effectiveness of family preservation services, this measure has been used by promoters of the intensive family preservation model to tout its benefits. Consequently, they believe it is appropriate to use placements as an outcome measure in testing the effectiveness of the model. They also point out that the carefully controlled research that did attempt to measure outcomes other than placement in foster care found no statistically significant differences between the treatment groups and the control groups in family functioning.

We find that the objections raised by critics of recent family preservation research suggest weaknesses in the family preservation program as much as with the research on the program. In our view, the cited problems suggest that the program, as it has been formulated by most state and local child welfare agencies, is being used for many families who are unlikely to benefit from family preservation services. They also suggest a need for states to pay much more attention to implementation strategies, including development of good assessment tools and clear guidelines to be used by welfare workers who enroll families in the program.

Michigan's Families First Program

One program that has attracted the attention of researchers and program advocates throughout the country is Michigan's Families First Program. We give it special attention in this chapter because the Department of Social Services' child welfare program management has cited it as an example of research that demonstrates the effectiveness of family preservation services.

An evaluation of the Families First Program, conducted by University Associates and published in March 1993, compared 225 children, referred to the program by State of Michigan child welfare workers because they were at "imminent risk of placement," with a "matched group" of children who exited foster care during the period in which the treatment

group was enrolled for services.[56] According to the evaluators, 24 percent of the treatment group had been placed in foster care at 12 months after treatment ended, whereas 35 percent of the control group had been placed in foster care. This difference in placement rates was statistically significant. A follow-up evaluation conducted in 1995 showed similar differences in placement rates between the treatment and control groups, although the placement rates had increased for both groups at 36 months after treatment ended.[57]

These findings, together with the decrease in the number of children placed in foster care in Michigan in 1992, four years after the Families First Program was implemented, have been cited as evidence that Michigan's family preservation program is effective in avoiding unnecessary foster care placements. However, we have two major concerns with this interpretation. First, in our view and that of several respected researchers,[58] the findings of the Michigan evaluation are flawed in that the research does not involve a valid comparison group. The Michigan researchers contend that the treatment and control groups were well-matched (i.e., they were comparable in terms of risk of placement), based on a comparison of five characteristics: county of residence; type of referral (report of abuse, report of neglect, delinquency, or family reunification); prior involvement with children's' protective services; the time period during which the child left foster care or was selected for treatment; and the child's age. However, with the possible exception of "prior involvement with children's' protective services," these characteristics have not been shown to be related to placement outcomes.[59] Furthermore, the evaluators did not ensure that the treatment and comparison groups were comparable in several characteristics that have been shown to be related to placement outcomes (e.g., behavioral problems present in the abused/neglected child, the presence of mental health problems in the caregiver, and the total number of different risk conditions present).[60] Without additional analysis of characteristics of the two groups, it is impossible to say that they were comparable.

Second, we are aware of no analysis of possible alternative causes of the decrease in new foster care placements experienced by Michigan beginning in 1992. The literature on child welfare contains many references to the sometimes dramatic impact of changes in child welfare agency policies on foster care placement rates. Two examples of policy changes that

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[56] University Associates, Evaluation of Michigan's Families First Program, Summary Report, Lansing, MI: University Associates, March 1993.

[57] University Associates, Evaluation of Michigan's Families First Program, Summary Report, Lansing, MI: University Associates, 1995.

[58] See, for example, Littell, J.H., and Schuerman, J.R., A Synthesis of Research on Family Preservation and Family Reunification Programs, Rockville, MD: Westat, Inc., May 1995, pp. 4-5; and Schwarz, I.M., "The Systemic Impact of Family Preservation Services: A Case Study," in Schwartz, I. M., and AuClaire, P. (eds.), Home-Based Services for Troubled Children, Lincoln: University of Nebraska Press, 1994, pp. 157-171.

[59] However, "age" and "reason for referral to children's protective services agencies" have been used to group children for the purpose of statistical analysis because the factors that appear to be related to placement in foster care seem to be different for children of different age groups and referral types.

[60] Bath, H.I., Richey, C.A., and Haapala, D.A., "Child Age and Outcome Correlates in Intensive Family Preservation Services," Children and Youth Services Review, 14, 1992, pp. 389-406.

had large effects on foster care placements are New York State's children services agency's reversal of its policy of immediately placing new-born infants with positive drug toxicity reports in foster care[61] and Sacramento County's welfare agency's policy, adopted in response to a highly-publicized death of a child, of assigning higher risk ratings to information ascertained during investigations of child maltreatment.[62] At least one respected researcher has observed that recent policy changes in Michigan regarding the definition of abuse and neglect and the evidence required to substantiate abuse and neglect led to a decline in that state's substantiation rates for reports of abuse and neglect.[63] This alone could have resulted in a significant reduction in foster care placement rates in Michigan. Until a thorough analysis of possible alternative explanations of the decrease in Michigan's foster care placements, including policy and procedural changes, has been performed, we must consider Michigan's association of its decrease in foster care placements with the implementation of its Families First Program to be speculative.

Evaluation of California's Family Preservation Program

In 1984, eight counties were authorized by AB 1562 to implement a three-year demonstration program of intensive family preservation services using the Homebuilders model and targeting children at imminent risk of placement in out-of-home care. An evaluation of the program was submitted to the Department of Social Services in 1990.[64] The evaluation concluded that there was no statistical evidence that the program was effective in reducing placement rates or reducing subsequent incidents of abuse and neglect. The study also found no statistically significant differences in the percentage of treatment and control families experiencing subsequent reports of abuse or neglect.

In 1988, the State began another family preservation demonstration program under AB 558. In this case, three counties (Alameda, Solano and Napa Counties) were selected to participate. Unlike AB 1562, the new legislation provided the implementing counties more flexibility in the type of intensive care family preservation program they could implement. Moreover, although children at risk of placement continued to be one of the target groups, children in family reunification programs also were targeted. In addition, the legislation established criteria by which the success of the demonstration program was to be judged. The criteria were that (1) at least 75 percent of the children served by the program remain at home for six months after receiving services and that at least 60 percent of the children

[61] New York Department of Social Services staff indicated that, together with a decline in the documented incidence of crack cocaine usage, this change in policy has largely been responsible for New York's being the only major state experiencing a significant decline since 1991 in the number of children in foster care.
[62] Sacramento County Department of Health and Human Services staff indicated that foster care placements increased by 50 percent in Sacramento County within six months after the incident occurred.
[63] Schwartz, I.M., op. cit., p. 162.
[64] Yuan, Y.T., McDonald, W.R., Wheeler, C.E., Struckman-Johnson, D., and Rivest, M., Evaluation of AB 1562 In-Home Care Demonstration Projects (Final Report), Sacramento, CA: Walter R. McDonald and Associates, Inc., 1990.

remain at home for at least a year after receiving services; and (2) the average length of stay in out-of-home care be no more than 50 percent of that for the average family that does not receive services. The statute establishing the demonstration program was amended several times, among other things allowing twelve additional counties to participate and specifying the following additional success criteria: at two years after the families receive services: (1) the average length of stay in out-of-home care for children receiving family preservation services should be no more than 50 percent of that of children not receiving services; and (2) at least 60 percent of the children returned home after receiving family reunification services should remain at home.

The 12-month evaluation of the AB 558 program showed that counties generally met most, but not all, of the six- and twelve-month success criteria specified in statute.[65] The evaluation also found that families receiving family preservation services showed an increase in their family functioning, as measured by their scores on a relatively new research-based clinical tool. We note, however, that although the improvements in family functioning demonstrated by program participants were statistically significant, the changes were marginal. Table 4-1 displays those results.

TABLE 4-1
FAMILY FUNCTIONING SCORES OF PROGRAM PARTICIPANTS

Category of Functioning	Mean Scores		
	Intake	Termination	Change
Caregiver Interaction	2.68	2.53	0.15
Developmental Stimulation	2.64	2.49	0.15
Financial Conditions	2.60	2.38	0.22
Living Conditions	2.31	2.17	0.14
Parent-Child Interactions	2.68	2.48	0.20
Support to Parents	2.51	2.34	0.17

These results are especially problematic because the average score at intake suggests that the families were functioning at a fairly high level relative to families usually targeted by intensive family preservation programs. Families with a score of "2" are regarded as "generally

[65] Walter R. McDonald & Associates, County Family Preservation Program Evaluation: Six and Twelve Month Follow-Up Report, Volume I (Draft), Sacramento, CA: Walter R. McDonald & Associates, November 1996.

adequate," and families with a score of "3" are regarded as having "problems of a moderate nature," for which "treatment or counseling or parent training are indicated." Given the subjective nature of many of the items used to determine a score in each category,[66] we question whether the differences displayed in Table 4-1 are meaningful in a programmatic sense.

Although the evaluation suggests that family preservation services in California generally may have been effective in most counties, we believe there is little one can really say about the effectiveness of the program. In the first place, because of resource limitations, the evaluation did not employ a randomly assigned control group. Consequently, one can conclude very little about the impact of the program per se on families receiving services. We are also uncertain that the criteria established for the program by the Legislature are true tests of the program's effectiveness. In particular, we have questions about the criteria that at least 60 percent of the children receiving family preservation services remain at home at 12 months and that at least 60 percent of the children who receive services and are returned home must remain at home for the 12-month follow-up period.

With respect to the first criterion, studies of family preservation programs found that between 56 and 76 percent of the children receiving family preservation services remained at home at 12 months after receiving treatment. About half the studies found that about 60 percent remained at home at 12 months after treatment, and half found that about 75 percent remained at home at 12 months after treatment. The 60 percent target therefore seems to be on the low side. Moreover, because several studies showed no statistically significant difference between treatment and control groups, we question whether even a target of 75 percent is meaningful.

With respect to the second criterion, the California Foster Care Information System (FCIS) data published by the Child Welfare Research Center of the University of California, Berkeley, indicate that approximately 80 percent of the children who are admitted to foster care for the first time and are subsequently returned home do not return to foster care within 36 months after being discharged.[67] We are unable to determine the comparability of these children, all first-time entrants to foster care, with those served under AB 558, and we do not mean to imply that this comparison suggests that the family preservation and reunification services provided by the demonstration project were ineffective. We raise this issue merely to point out the difficulty of assessing the reasonableness of the AB 558 criterion as a measure of effectiveness of the program. Until an analysis of the FCIS data and the AB 558 data has been performed, we are unable to conclude anything about the effectiveness of the family preservation program from the AB 558 evaluation.

[66] See Appendix E for a list of items for the six categories of family functioning tracked during the evaluation.
[67] University of California, Berkeley, Child Welfare Research Center, Performance Indicators for Child Welfare Services in California, Sacramento, CA: California Department of Social Services, November 1996, p. 115 (Table 8.1).

CONCLUSIONS AND RECOMMENDATIONS

After reviewing the published summaries of research on intensive family preservation services and many of the original research articles and reports, we must conclude that the effectiveness of the program is unknown. The most methodologically rigorous research on intensive family preservation services has produced inconclusive findings about the effectiveness of the services. In many of these studies, there were no significant differences in foster care placement rates between the treatment group and the control group. In some cases, there were statistically significant differences but they were in the opposite direction one would hope, i.e., the families who did not receive family preservation services had better outcomes than did those who received the services.

Moreover, the research on family preservation programs raises questions about whether family preservation programs serve the intended population, i.e., families truly at risk of having children placed in foster care, and about the effectiveness of services provided to families served by the program. Serious questions have been raised about child welfare agencies' ability to identify children at imminent risk of removal from their homes and, consequently, their ability to appropriately target family preservation services.[68]

During our field work, we frequently heard from Department of Social Services and county children services agencies staff and management about the need for additional resources to help families deal with their problems so that their children would not need to be placed in out-of-home care. Despite the appeal of this argument, we found no evidence that the services provided by the family preservation program are effective in achieving the desired outcomes.

As noted above, the federal government recently has begun funding ongoing family preservation and support services programs. Although funds have been set aside to evaluate the program, the evaluation will cover mainly process issues. Moreover, because the State has chosen to give counties the maximum amount of flexibility in implementing the program in ways that meet their own needs, it is unlikely that an evaluation methodology can be constructed to measure the effectiveness of the program in achieving specific outcomes. In light of this, *we recommend that policy-makers in the Legislature and the Administration take a conservative approach to funding family preservation programs. New State funding should be appropriated only for specific services for which there is solid evidence of success in achieving outcomes targeted by the Legislature and the Governor.*

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[68] See, for example, Blythe, B., Salley, M., and Jayaratne, S., "A Review of Intensive Family Preservation Services Research," Social Work Research, 18(4), December 1994, pp. 213-224. Although some experts have attributed this to the complexity of the process required to remove a child from his/her home, it is also possible that child welfare agencies find it difficult to implement policy changes uniformly across the agency. Another possibility is that child welfare agencies lack good risk assessment tolls for determining children's risk of removal from their homes. This issue will be discussed in Chapter 7.

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CHAPTER 5
HOME VISITING

INTRODUCTION

The concept of government agencies providing services to persons in their homes is not a new one, but has existed for years, albeit at times by different titles such as "in-home services," "home based services" and "in-home support." In an article prepared by Barbara Hanna Wasik,[69] the author traces home visiting to England to the Elizabethan times where visitors provided care to the poor in their own homes. The author also noted that visiting nurses were part of social service efforts in the United States at the turn of the twentieth century. As the following quotes exemplify, child and family welfare observers have long understood the importance of home visiting[70]:

> *Many earnest workers in charity feel that social conditions could be wonderfully improved if, to every family in distress, could be sent a volunteer visitor, who would seek out and, with patience and sympathy, strive to remove the causes of need.*
> *(M.E. Richmond, 1899)*

> *As a bridge between the young families and health services, the utilization of visiting nurses, or more often in most places, indigenous health visitors who are successful, supportive, mature mothers acceptable to their communities is...the most inexpensive, least threatening, and most efficient approach for giving the child the greatest possible chance to reach his potential.*
> *(C.H. Kempe, 1976)*

> *All health, education, and social support programs dealing with young children should have a family support/home visiting component as an option for families.*
> *(R.N. Roberts, 1988)*

Despite this early beginning, home visiting programs have gained renewed interest and enthusiasm since the 1980s as child and family welfare experts and researchers express concern about the health and social risks to substance-exposed children. Recognizing the immediate as well as the long-term affect of alcohol and drugs on children, they have turned their attention to prevention and early intervention programs. In the United States, home visitation programs have been, or will soon be, implemented statewide in some states such as

[69]Wasik, B.H., "Home Visiting", The Future of Children, 3(3), Winter 1993, page 140.
[70] Ibid., page 6.

Hawaii and Vermont. On a smaller scale, home visitation programs have operated or are currently operating in several other states including California, Colorado, Florida, New York and Tennessee. One home visitation model, the Healthy Families America Model, has been replicated in more than half of the states in more than 124 sites.

The increased attention to home visiting that has occurred since 1990 may have been due in part to the publication of a U.S. General Accounting Office report concluding that home visiting programs have the potential to produce great improvements in maternal and child health and well-being for at-risk families.[71] In addition, since 1990, several influential child welfare advocacy groups have promoted their use.[72]

Home visiting currently is being used in many disciplines. It is used by health agencies in an attempt to improve the health of newborns and infants, by child welfare agencies to prevent child maltreatment or to avoid placement of children in foster care, by education agencies to improve child development for young children, by criminal justice agencies to prevent juvenile delinquency and by mental health agencies to remediate developmental delays or improve the mental well-being of their clients.

The theory behind home visiting is that services rendered in the home are more likely to benefit clients than are services rendered through the more traditional delivery systems. When we began this evaluation of child welfare programs, Department of Social Services management was actively promoting home visiting of pregnant women who possessed characteristics that are thought to be correlated with child abuse and neglect. According to the department, home visiting has tremendous potential for reducing the incidence of child abuse and neglect among this high-risk group and for improving the health and educational development of children born to this group of women. Because of the potential benefits of home visiting, the Administration, in the 1997-98 Governor's Budget, is proposing a $10 million home visiting initiative (the Infant Health and Protection Act initiative) to address child abuse and neglect among a specific high-risk population, substance-abusing parents.

An extensive amount of research has been performed regarding the effectiveness of home visiting in achieving child welfare outcomes. In this chapter we summarize recent evaluations of home visiting programs that focus on pregnant women and mothers of young children and that have as one of their objectives the reduction of child maltreatment or improvement in various aspects of parenting skills or infant development. We have chosen not to review research designed primarily to measure the effects of in-home services on educational gains

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[71] General Accounting Office, Home Visiting: A Promising Early Intervention Strategy for At-Risk Families, Washington, D.C.: Government Accounting Office, 1990, GAO/HRD-90-83.

[72] In 1991, the U.S. Advisory Board on Child Abuse and Neglect recommended that the federal government provide universal home visiting for mothers and children during the neonatal period. The Board's position is set forth in Krugman, Richard D., "Universal Home Visiting: A Recommendation from the U.S. Advisory Board on Child Abuse and Neglect," The Future of the Children, 3(3), 1993, pp. 184-191.

because they are considered by department staff to be too narrow in scope to be considered comparable to the home visiting initiative currently being proposed by the Administration.

SUMMARY OF RESEARCH ON HOME VISITING

For our review of research on home visiting (see Appendix F), we have relied to a great extent on two reviews of the literature, one conducted by Olds and Kitzman[73] and the other conducted by Wekerle and Wolfe.[74] Both reviews concentrate primarily on research using methodologically rigorous designs, i.e., those using randomly assigned treatment and control groups and those in which attempts are made to carefully control for differences among groups.

One of the authors, David Olds, has published many articles about the effectiveness of home visiting and is highly respected for the quality of his research. His findings, as well as findings from Vermont and Hawaii, have been cited by the Department of Social Services to indicate the benefits that result from home visiting. In several journal articles, he has presented his findings from a study of 400 families in Elmira, New York, conducted during the late 1970's. In those articles, he concluded that home visiting programs can result in a significant reduction in verified cases of child abuse (at least for young, low-income, first-time mothers[75]), a reduction in infants' visits to emergency rooms, and an increase in the mother's employment during a two-year period following the receipt of home visitation services. However, in his and Kitzman's comprehensive review of scientifically-designed research on home visiting, he has concluded that other research conducted has not confirmed his Elmira findings.

Olds has speculated about the reasons for the success of the Elmira project, suggesting that the essential ingredients for success of home visiting programs are (1)use of nurses to provide home visiting services, (2) beginning the home visits during the prenatal stage, (3) visiting frequently (at least once a week during the critical prenatal and postpartum periods), and (4)providing comprehensive services that address all the social, behavioral and psychological factors bearing on the health and well-being of pregnant women and their young children.[76] However, he acknowledges that only additional research will be able to resolve the questions about the effectiveness of home visiting programs.

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[73] Olds, D., and Kitzman, H., "Review of Research on Home Visiting for Pregnant Women and Parents of Young Children," The Future of Children, 3(3), 1993, pp. 53-92.

[74] Wekerle, C., and Wolfe, D., "Prevention of Child Physical Abuse and Neglect: Promising New Directions," Clinical Psychology Review, 13, 1993, pp. 501-540. We did not review studies reviewed by Wekerle and Wolfe that employed samples of less than 20 for either the treatment or control group or studies with only an educational emphasis. This eliminated six studies reviewed by Wekerle and Wolfe.

[75] Olds' research was unable to find similar effects for other groups of women.

[76] Olds, D., and Kitzman, H., "Can Home Visiting Improve the Health of Women and Children at Environmental Risk?," Pediatrics, 86(1), July 1990, pp. 108-116.

Regarding specific findings presented by Olds and Kitzman and Wekerle and Wolfe, the authors found some evidence that home visiting has a positive effect on health of mothers and children, but the results for other outcomes thought to be benefits of home visiting (reductions in child maltreatment, improvements in children's cognitive development, improvements in mothers' parenting skills, and improvement in mothers' health-related behavior) were at best mixed. For example, of 15 studies emphasizing cognitive and linguistic development of infants, only six showed a statistically significant positive impact of home visiting on cognitive development, and only seven showed a statistically significant positive impact on parental caregiving. Wekerle and Wolfe reviewed seven additional studies in which infants' cognitive and linguistic development were evaluated. In two of those studies, they reported no differences between the treatment and control groups. In the other five studies, they found differences favoring the treatment groups, but the statistical significance of the difference was not reported. They also reviewed nine studies that assessed the impact of home visiting on the caretakers' parenting abilities and found mixed results.

The research findings regarding the impact of home visiting on child abuse and neglect has been especially disappointing. None of the six studies reviewed by Olds and Kitzman that evaluated the impact of home visiting on child abuse and neglect found a statistically significant relationship between home visiting and child welfare agencies' reports of child maltreatment. Furthermore, only four of ten studies that used proxies for child maltreatment, such as infant emergency room visits, illness, injuries or ingestions, found a positive, statistically significant relationship between home visiting and child maltreatment. Even for the four studies that found a positive impact, there is some doubt about the long-term impact of home visiting on child maltreatment. One of the few studies that measured effects two years after home visiting ended (Olds' Elmira study) found a statistically significant reduction in child maltreatment among a select group of women 12 months after home visiting ended, but found no statistically significant difference in maltreatment rates for the treatment and control groups at 24 months after the home visiting ended.[77]

Perhaps the most encouraging results of home visiting programs on child maltreatment come from a study that neither Olds and Kitzman nor Wekerle and Wolfe reviewed, an evaluation

[77] The department cites the Elmira study in its Infant Health and Protection Home Visiting Pilot Program Budget Change Proposal as evidence that home visiting produces an 80 percent reduction in verified CPS (child protective services) cases. We believe the department's reference to the Elmira project's findings for this purpose is problematic, not only because the Elmira study found the impact of home visiting on child maltreatment reports to be short-term in nature, but also because the Elmira results apply only to low-income, unmarried teenagers who had never before given birth and who received comprehensive home visiting during the prenatal, as well as postpartum, period. It is conceivable that the success of the Elmira project is attributable to its providing services during the prenatal period, when a future mother's behavior is more easily influenced, and to the fact that the project served only first-time mothers. Under the home visiting program proposed in the Governor's Budget, it is likely that few women will be participating in the program during the prenatal period and that many participants will have had other children.

of Hawaii's Healthy Start Program.[78] The Hawaii study showed that home visiting produced statistically significant improvements in parental attitudes toward children, parent-child interaction patterns and the "type and quality" of child maltreatment. Both the treatment group and control group experienced reductions in their potential for physical abuse of their children, as measured by their scores on standardized tests, 12 months after being assigned to one of the study groups (treatment or control). However, the mothers who were part of the treatment group experienced a 34 percent reduction in their abuse potential while the control group experienced only a 10 percent reduction. Furthermore, this difference was statistically significant even after between-group differences in maternal age, employment status, educational attainment and self-esteem were accounted for. Similarly, child maltreatment was confirmed in six instances (four percent) for the treatment group and 13 instances (eight percent) for the control group, a statistically significant difference. Because of problems with the intake process, the Hawaii study was not able to measure the impact of the program beyond 12 months.

Two other home visiting programs deserve special attention because the Department of Social Services stressed them repeatedly as evidence of the effectiveness of home visiting. These are Vermont's Healthy Babies program and the U.S. Marine Corps' New Parent Support Program. Each is discussed below.

VERMONT'S HEALTHY BABIES PROGRAM

The department informed us that Vermont's Healthy Babies Program has demonstrated the effectiveness of home visiting programs by reducing the number of substantiated incidents of child abuse and neglect by 27 percent statewide since 1992, when the program was initiated. When we contacted Vermont officials to verify this and to request data showing the effectiveness of the program, we were informed that the program is too new to have data to demonstrate its effectiveness. We also were informed that the program has not yet been fully implemented statewide. Vermont's Department of Social and Rehabilitation Services has just begun collecting the data necessary to demonstrate the program's effectiveness.

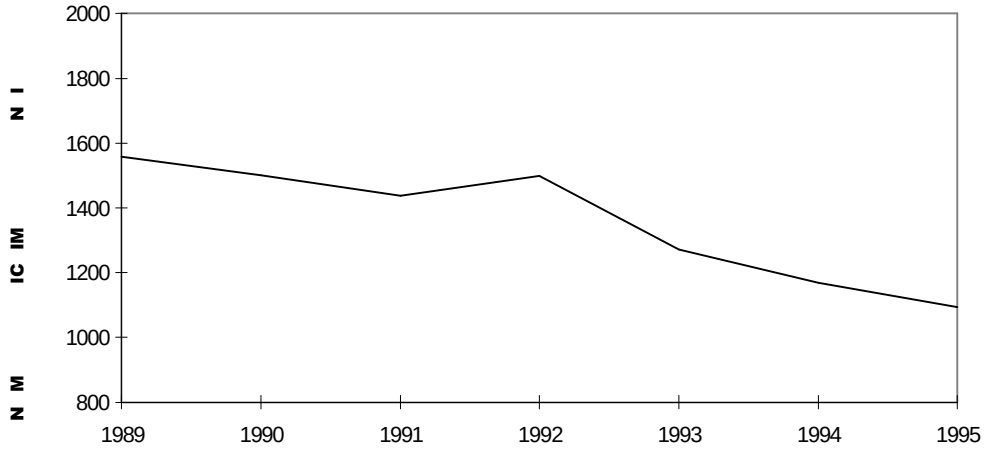
It is also important to note that the State of Vermont is not claiming that the decline in abuse and neglect cases since 1992 is attributable solely to home visiting. A recent press release of the Commissioner of Vermont's Department of Social and Rehabilitation Services attributes the decline to "prevention efforts like Success by Six and Healthy Babies, along with community based parent-child centers and assertive action to protect abused children through

[78] There have been at least two evaluations of Hawaii's Healthy Start Program, and a third currently is underway. However, until the National Committee to Prevent Child Abuse (NCPCA) conducted a randomized experiment for the federal National Center on Child Abuse and Neglect, evaluations of the Hawaii program had not been designed to provide scientifically valid results. We report here on the NCPCA study, which was published in Daro, D., Intensive Home Visitation: A Randomized Trial, Follow-up and Risk Assessment Study of Hawaii's Healthy Start Program, Final Report, Chicago: National Committee to Prevent Child Abuse, June 15, 1996.

law enforcement, aggressive prosecution and treatment and counseling programs."[79] Department representatives with whom we spoke placed a greater emphasis on the use of community-based parent-child centers than the Healthy Babies Program in producing a decline in reports of abuse and neglect. We note, however, that no analysis of data has been done to determine if statistically significant relationships exist between reports of child abuse and neglect and any of the factors mentioned in the press release.

To determine whether the period, 1992 through 1995, truly reflects a change in abuse and neglect trends, we requested data from Vermont on the number of substantiated reports of abuse and neglect since 1989. The data were used to prepare Figure 5-1, which indicates that there was a declining trend in the number of reports of abuse and neglect even before 1992. Furthermore, whereas abuse and neglect victims decreased 27 percent between 1992 and 1995, if the trend between 1989 and 1991 simply continued, the number of abuse and neglect victims in 1995 would have been 19 percent lower than the number of victims in 1992 - even without the home visiting program.[80] Clearly, there is a need for additional analysis before one can assume, as has the Department of Social Services, that home visiting in Vermont has produced a significant decrease in child abuse and neglect.

FIGURE 5-1
VERMONT CHILD ABUSE AND NEGLECT TRENDS



U.S. MARINE CORPS NEW PARENT SUPPORT PROGRAM

The U.S. Marine Corps New Parent Support Program, which operates at all 18 Marine Corps installations, is designed to provide home visiting services to military families with children

[79] Press release dated March 21, 1996.
[80] During the period, 1989 to 1995, it appears that 1992 reports can be regarded as an anomaly and should not be used as a base year for comparison purposes. Even Vermont's Department of Social and Rehabilitation Services has chosen to use 1993 as its base year in measuring the effectiveness of its Healthy Babies Program.

age six or less in which a known or suspected incident of child or spousal abuse has occurred. According to information provided by researchers who are in the process of evaluating the program that is operating at Camp Pendleton, California, the families treated by the program have shown statistically significant improvements in three of four standardized instruments used to measure the families' risk status. In addition, new instances of child maltreatment have occurred in only 10 percent to 12 percent of the families who have participated in the program for 12 months. The department has relied on this information as evidence that home visiting has been shown to be effective in minimizing child abuse among military families.

Although we believe the Camp Pendleton data would have some value in indicating the effectiveness of home visiting programs in minimizing child maltreatment among military families if the same results were to be observed two to three years after treatment ends, we have two concerns about the use of the information cited above for demonstrating the effectiveness of home visiting programs generally. First, no control groups have been employed for the evaluation of the New Parent Support Program.[81] Until comparable data are collected for a carefully selected control group and statistical analyses of the two sets of data are performed, we are unable to attribute the results cited in the above paragraph to the home visiting program. Second, we believe the New Parent Support Program is not representative of home visiting programs that could be implemented by public child welfare agencies. The commanding officers of the military personnel who are receiving treatment under the program are aware of the involvement of their subordinates in the program and are likely to place pressure on them to modify their behavior, with results that no public agency can hope to achieve with members of the public. Consequently, we find the New Parent Support Program of little use in determining whether home visiting programs of the type being proposed by the Department of Social Services are effective in reducing child maltreatment.

SUBSTANCE ABUSE TREATMENT AND PARENTING TRAINING

As noted earlier in this chapter, the Administration is proposing a $10 million home visiting initiative for 1997-98. The initiative proposes identifying newly born children who have been exposed to controlled substances and, where appropriate providing intensive home visitation and substance abuse treatment services. The home visiting component of the initiative will be modeled after the programs operating in Hawaii and Denver. However, unlike those programs, the initiative emphasizes maltreatment by substance-abusing parents and provides funding for substance-abuse treatment for those parents. The budget change proposals submitted by the Department of Social Services and the Department of Alcohol

[81] This point was stressed in a May 20, 1996 memo to the Department of Social Services from the researcher who is responsible for evaluating the program.

and Drug Programs, on which the proposal in the Governor's Budget is based, assumes that the presence of a home visitor "will help prevent relapse once an individual has completed treatment. Thus, there should be no additional costs for substance abuse treatment in the second and third year of a family's participation in the demonstration." Given the results of research on substance abuse treatment presented in Chapter 6, especially findings regarding the high rates of recidivism and the relatively low percentage of patients who remain abstinent for extended periods of time, the department's assumptions about substance abuse treatment costs diminishing greatly after the first year of treatment should be carefully scrutinized as the initiative is implemented.

Another consideration for the department's implementation of the Administration's initiative is the difficulty of obtaining the cooperation of home-visited parents in attending parenting training classes or group sessions. Olds' noted that parents at risk of child maltreatment are unlikely to attend parenting classes and found that one home visiting project he reviewed had to eliminate group sessions from the study because so few parents attended.[82] This also was a problem noted in the evaluation of Hawaii's Healthy Start Program, where the researchers found that 65 percent of the parents never attended a parent group session and that during the last six months of the 12-month evaluation period only 13 percent of the families attended even one session.[83]

CONCLUSIONS AND RECOMMENDATIONS

In our judgment the research on the effectiveness of home visiting programs in reducing child maltreatment is mixed, and we are doubtful that future research will resolve the issue. The incidence of child maltreatment in the population is relatively low (estimates range from 2 percent to 10 percent, with most estimates at the low end of the range) for tests of statistical significance to produce consistently positive results unless the sample sizes used in the studies are much larger than has been used to date. Moreover, according to many child welfare researchers, programs that involve increased oversight of the treatment group, such as home visiting or family preservation programs, are likely to identify incidents of child maltreatment that would not ordinarily come to light. These reported incidents tend to offset any reduction in abuse and neglect that might otherwise occur as a result of the program, thereby introducing a bias into the evaluation. Another obstacle mentioned by many researchers, perhaps the most important obstacle, is the overwhelming problems facing many parents with whom children services agencies must deal, including economic problems and abusive behavior learned over a lifetime. It is difficult to imagine a short-term program of home visiting offsetting problems of this magnitude.

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[82] Olds, D., and Henderson, C., "The Prevention of Maltreatment," in Cicchetti, D., and Carlson, V. (eds.), Child Maltreatment: Theory and Research on the Causes and Consequences of Child Abuse and Neglect, Cambridge: Cambridge University Press, p. 724.

[83] Daro, op. cit., p. 88.

Our review of the literature also raises questions about the long-term benefits resulting from home visiting. Unfortunately, few of the studies employing methodologically rigorous research designs conducted follow-up studies two or more years after the treatment ended. The few that did obtained mixed results, with some studies indicating that the benefits of home visiting diminish over time. This raises questions about the need to provide ongoing, or periodic, services to a large percentage of the at-risk population, similar to what is required for many substance abusers.

Another issue raised by the research is the importance of how the home visiting program is structured. There is a tremendous amount of variation among home visiting programs. Some home visiting programs begin during the prenatal period, others immediately after children are born, and others with little regard to the children's ages. Some home visiting programs last only three to six months, others last 12 months, and others last as much as 3 years. Some provide monthly visits, others weekly or biweekly visits. Some home visiting programs employ only professionals (in particular nurses or skilled social workers), others only paraprofessionals, others teams of professionals, and others combinations of professionals and paraprofessionals. Some programs provide only parenting education, others provide health care as well as parenting education, and others offer a comprehensive range of services, including parenting education, counseling, health care, connecting mothers with a wide range of service providers, and assisting parents in structuring home environments. These dissimilarities have led to uncertainty among researchers about the applicability of the results of one study, or a group of studies, to home visiting programs with different characteristics.[84]

Although there is no consensus among child welfare experts about the characteristics that are important in a successful home visiting program, there seems to be some evidence that the frequency of the home visits and the timing of the onset of services are important. A growing number of experts advocate beginning the services during the prenatal period and holding weekly visits, especially right after a child is born.[85] Many experts also believe that home visiting programs for high-risk families must operate for more than a year if they are to have the desired effect. The need for longer periods of home visiting has been indicated by several research studies that showed a positive relationship between the length of treatment and desirable outcomes.

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[84] Several child welfare experts have commented on the great diversity among programs labeled as "home visiting." See, for example, McCurdy, K., Home Visiting, Chicago: National Committee to Prevent Child Abuse, December 1995, p. 29, and Weiss, H., "Home Visits: Necessary but Not Sufficient," The Future of the Children, 3(3), 1993, p. 113.

[85] McCurdy, ibid., pp. 29-31, and Weiss, ibid., pp. 120-121. Weiss also believes that both available research and theory argue in favor of comprehensive home visiting programs. She notes that parents are more likely to focus on parenting and child development if their basic needs (food, shelter, health care, transportation, child care, etc.) are provided (p. 120).

Finally, the evaluation of Hawaii's Healthy Start Program pointed to the difficulty in properly identifying families likely to benefit from home visiting. In particular, it pointed to the weakness of existing screening instruments in adequately measuring risk of maltreatment and the need for multiple assessments of risk to adequately target families likely to benefit from home visiting. The Hawaii evaluation found that about 25 percent of those categorized as "high risk" at intake (using the "Family Stress Checklist") were misclassified, based on subsequent assessments of risks using risk assessment instruments employed after intake. In addition, about 25 percent of those categorized as "low-risk" and therefore screened at intake were misclassified and should have received services.[86] It also found that the correlation between risk as measured by the Family Stress Checklist and risk as measured by a battery of other risk instruments, diminishes over time, i.e., the correlation between the instruments is higher for assessments performed six months after intake than for assessments performed 12 and 18 months after intake. According to the author of the Hawaii evaluation: "No single assessment tool administered at a single point in time can be expected to correctly identify all those at risk for maltreatment."[87] Typically, home visiting programs such as one the San Diego Healthy Families Program discussed in Chapter 6 have used hospital records and a subsequent in-person interview to identify at-risk families for which home visiting is thought to be effective. However, the Hawaii study suggests a need to reevaluate the screening process used in these programs.

Unlike family preservation programs, there have been few large studies of the effectiveness of home visiting programs. Despite the uncertainty about the effectiveness of home visiting in reducing child maltreatment, there is enough research suggesting that the program may have positive benefits for some families that the program's effectiveness should be further evaluated in California. We believe the department's funding of several pilot projects (discussed in Chapter 6) and the Administration's initiative for the pilot project proposed in the 1997-98 Governor's Budget are reasonable approaches to testing the effectiveness of the program. However, to ensure that the Administration's initiative produces information that can be used to make future decisions on expanding home visiting programs in the State, *we recommend that prior to program implementation the department develop an evaluation methodology that is designed to demonstrate the program's effectiveness in producing desirable child welfare outcomes.*

[86] Daro, op. cit., pp. 51-55.
[87] Ibid., p. xii.

CHAPTER 6
PILOT PROJECTS & SERVICES

INTRODUCTION

Focusing on efforts to improve the State's child welfare system, in recent years California established and funded several pilot and demonstration projects to test the effectiveness of new and innovative methods of delivering child welfare services. In addition, through its "Best Model/Best Practices" seminars and statewide training sessions, the Department of Social Services has shared several innovative and promising child welfare service approaches with local communities. This section of the report describes some of the projects and new approaches to delivering services. In most cases, assessments or evaluations measuring the success of the projects in achieving desired outcomes are not available. Some of the projects, for example the federal Family Preservation and Family Support Program and Family Unity Model are in their initial development or implementation phases. As a result, data are not available to measure the projects' successes. In other cases, rigorous scientifically designed research efforts have not been conducted due to the cost of such efforts. In these cases, clinical observations and anecdotal information form the basis for conclusions about a project's success. To the extent that information about a project's reported success is available, it will be included in this discussion.

Also, in this Chapter, as another way of judging the effectiveness of California's child welfare system, we present our review and assessment on two service programs that are used extensively throughout the system. In particular, we comment on the effectiveness of parenting training and counseling, and substance abuse treatment in reducing child abuse and neglect.

COUNTY FAMILY PRESERVATION PROGRAM

While California experimented with earlier intensive in-home child welfare services programs intended to preserve the family unit, such as the Homebuilders model in 1984,

today's family preservation model first originated in the State in 1988.[88] Unlike earlier family preservation models, the later model allowed counties greater flexibility in designing family preservation programs that would reduce the number of children in out-of-home care. This model started as a two-year demonstration program in three California counties: Alameda, Napa and Solano. Based on the reported successes of the three counties in achieving the "success criteria" contained in the enabling legislation, in 1990, the pilot program was continued and participation was extended to 12 additional counties. In 1991, State legislation opened the program to any county and also modified the way the State and counties shared the non-federal costs for a variety of social and health services, including family preservation. Further, the legislation (AB 948) required the Department of Social Services to evaluated the effectiveness of the Family Preservation Program. Subsequent legislation in 1992 and 1993 made additional changes to the funding and service components of the program.

While the 1991 legislation opened the program to statewide participation, the statute did not mandate it. Instead, due to the establishment of the federal Family Preservation and Support Program (discussed in the next section), only a total of 16 counties elected to participate in the State program. Of this number, 14 counties (Alameda, Contra Costa, Humboldt, Mendocino, Napa, Placer, Riverside, Sacramento, San Diego, San Luis Obispo, Santa Clara, Santa Cruz, Solano and Stanislaus) requested and were granted a one-time permanent transfer of funds from the Foster Care allocation to child welfare services for purposes of this State program.[89]

Based on current State law, family preservation services means "...intensive services for families whose children, without these services, would be subject to any of the following: (I) Be at imminent risk of out-of-home placement. (II) Remain in existing out-of-home placement for longer periods of time. (III) Be placed in a more restrictive out-of-home placement."[90] The statute also establishes standards by which each county's family preservation program should be deemed successful if it meets the standards. (See Appendix G for a listing of the standards.)

To evaluate the Family Preservation Program (FPP) as required by AB 948, in 1991 the department contracted with Walter R. McDonald & Associates, Inc. (WRMA). In response, the firm has prepared and issued six reports on the family preservation program. In its latest report, *County Family Preservation Program Evaluation: Six and Twelve Month Follow-up Report*, the evaluators reviewed the family preservation programs in nine counties. Because Los Angeles County initiated its program one year after most other counties, sufficient information was not available to include the county in the evaluation. Nevertheless, a

[88] AB 558, Chapter 105, Statutes of 1988.
[89] Title IV-B State Plan Update for the Period October 1, 1996 to September 30, 1997, Department of Social Services, page 15.
[90] Welfare and Institutions Code Section 16500.5(a).

separate descriptive report on the Los Angeles County program was issued by WRMA in April 1996.

In its November 1996 report, WRMA states that "Conclusive demonstration that changes in family functioning were due to FPP participation would have required a comparison group, which was not possible for this evaluation."[91] Nevertheless, the report concluded that "all nine counties met most of the goals established through AB 776 for reducing out-of-home placements and time spent in care."[92] Moreover, the authors found that, for the most part, the county family preservation programs were effective in achieving the legislatively mandated success criteria. Our assessment of the findings of the evaluation is described in Chapter 4.

FAMILY PRESERVATION AND SUPPORT PROGRAM

With the passage of the federal Family Preservation and Family Support (FPFS) Act as part of the Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66), California was afforded the opportunity to enhance services to children who are at risk of abuse and neglect and their families. The following year, through AB 3364, the State Legislature created California's Family Preservation and Support Program (FPSP) and authorized the Department of Social Services to seek federal funds available under the Act. When authorizing the legislation, the Legislature noted that family support services are different from family preservation services because "...they do not have eligibility requirements, but they may be targeted at particular populations by being located in particular communities, and that the universal, voluntary nature of family support services is key to their effectiveness."[93] Further, the Legislature stated that family support services that are oriented to promotion and prevention can decrease the need for family preservation services.[94]

California received $6.9 million in new federal FPFS funds for Federal Fiscal Year (FFY) 1994 and $16.6 million in FFY 1995. The department expects the State to receive approximately $83.6 million over the next three years:

FFY 1996	$26.0 million
FFY 1997	$27.9 million
FFY 1998	$29.7 million

[91] WRMA, Inc., *County Family Preservation Program Evaluation: Six and Twelve Month Follow-up Report, Volumes I & II, November 1996*, page 1.25

[92] Ibid., page 6.2.

[93] Chapter 961, Statutes of 1994, Section 4 (AB 3364).

[94] In Chapter 4, we discuss our findings regarding our literature review on the effectiveness of family preservation programs and comment on the findings of the WRMA report.

As stated in California's Five-year Plan: "The purpose of the FPSP is to develop and expand a community-based continuum of coordinated and integrated, culturally relevant, family-centered services in California that will support and preserve families, protect children, prevent child abuse and neglect, and enhance the community's ability to provide assistance and support."[95] To this end, 57 of 58 counties participated in the program by establishing local planning bodies and by developing five-year plans. These local five-year plans form the basis for the State's five-year plan. The counties and the State are expected to update their plans annually.

By California statute, the State may retain 15 percent of the funds in each FFY for training and technical assistance, program monitoring and evaluation, State support and special projects.[96] The remainder of the funds are allocated to counties based on a ratio of the total population of children and the total number of children in poverty. Federal law requires that a minimum of 25 percent of the funds for family support services and a minimum of 25 percent on family preservation services. However, State statutes change those funding ratios for each county to not less than 50 percent and not more than 75 percent of the funds on family support services. Also, the statutes specify that counties cannot spend less than 25 percent nor more than 50 percent of the funds on family preservation services.

As part of its five-year plan development, each county developed individual goals and outcomes based on local community input. Annually, counties are required to evaluate their progress towards achieving their goals and objects. In addition, the department entered into an interagency agreement with the University of California Los Angeles (UCLA) to conduct an evaluation of the FPSP.[97] The evaluation is planned for three phases: the planning phase, the implementation phase and the outcome assessment phase. The evaluation will be limited to a representative sample of counties and will reflect a non-experimental design; i.e., the evaluation will not include carefully controlled observations of differential outcomes between treated and non-treated cases. The interagency agreement requires quarterly reports containing a brief summary of the quarter's activities; annual reports summarizing the prior year's observations and studies; and a final report, due in draft form by March 31, 2000.

The department reported that while some counties were able to spend all or part of their first year's allocation on services, most counties chose to use the allocation for planning and needs assessment.[98] As a result, the 12 month period ending September 30, 1996 was the first year in which all FPSP funds were used for services.

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[95] California Department of Social Services, *California's Family Preservation and Support Program, Five-year Plan 1994-1999*, Updated, October 1995, page 1.

[96] The first of the special projects funded by the State using FPSP funds is the Home Visitation Project in San Diego County. This project is discussed in greater detail later in this Chapter on page 51.

[97] UCLA subcontracted part of the evaluation with the University of Southern California and California State University at Long Beach. Together, the three universities formed the "Inter University Consortium" to conduct the evaluation.

[98] *California's Family Preservation and Support Program, Annual Progress Service Report for Fiscal Year 1995-96*, California Department of Social Services, August 1996, Executive Summary.

OPTIONS FOR RECOVERY

In the late 1980's, child welfare, health and substance abuse experts recognized the growing number of substance-exposed infants and children who tested positive with the human immunodeficiency virus (HIV) were entering the child welfare system. The child welfare experts also saw that few foster parents had the specialized training enabling them to provide the best care for these children. Moreover, these experts found foster parents caring for these high risk infants had a high burnout rate. In response, through the 1989 Budget Act and the Supplemental Report, the California Health and Welfare Agency was authorized to establish the State Interagency Task Force (SITF) comprised of the State Departments of Alcohol and Drug Programs, Health Services, Developmental Services and Social Services. The SITF was charged with the responsibility of increasing the availability of substance abuse treatment and case management services, and to provide out-of-home care options for children born substance-exposed who are at risk of abuse and neglect.

In the same year, State legislation was enacted which directed the Department of Social Services to develop and implement a three-year demonstration project in four counties to provide specialized services that assisted children in the foster care system who were substance-exposed or who tested HIV positive.[99] In particular, the law directed the participating counties to recruit, train and provide respite care to foster parents caring for court-dependent children under the age of 36 months who were alcohol- or drug-exposed or test HIV positive. This legislation authorizing the "Options for Recovery" pilot project also established standards by which the project could be deemed successful, and directed the department to report on the effectiveness of the project by December 31, 1992 while establishing a sunset date for the project of January 1, 1993. (See Appendix H for the project's success standards.)

The demonstration project had two goals. First, the project would limit the number of children in high-cost institutions such as hospitals or group homes.[100] In addition, the project would provide substance-exposed children with the less restrictive, more family-like placement consistent with the special needs and considerations of the children.

The original legislation targeted the Counties of Alameda, Los Angeles, Sacramento and San Diego. In 1990, subsequent legislative action expanded the pilot counties to include Contra Costa County and the five-county rural regional area of Butte, Glenn, Shasta, Siskiyou and Tehama. Later, in 1993, the Legislature extended the pilot project to June 30, 1994 but a 1994 bill[101] revised the sunset date to June 30, 1997 to allow the department ample opportunity to collect and analyze outcome data for its report to the Legislature. However, to

[99] Chapter 1385, Statutes of 1989 (SB 1173).
[100] The average group home rate during the demonstration period was $2,751 per month for each child. Families recruited under the this pilot project received an average of $550 per month per child.
[101] Chapter 148, Statutes of 1994 (AB 836).

date, the Department of Social Services has not submitted its report to the Legislature. Funds to continue the project through June 30, 1998 have been proposed in the Governor's 1997-98 Budget. The annual appropriation for the pilot project has been about $3.65 million of which $2.9 million is for respite services, $500,000 is for recruitment and $250,000 is for training.

In a draft report on the pilot project, the department reported that the project achieved its intended goals. Supporting this conclusion, the department stated that 39 percent of the participating project-eligible children during the pilot period achieved permanent placement compared to 26 percent of the non-pilot children.[102] In addition, the department reported that pilot children in the homes where parents had been trained spent an average of 149 fewer days in out-of-home placement and were more likely to be reunified with their biological families than children in other foster home facilities.

However, the department also reported that participating counties were able to place only 56.6 percent (2,197 of the 3,883) of the pilot-eligible children with specially-trained foster parents or with relatives.[103] While the pilot counties reported recruiting more than 3,000 potential foster parents, 2,000 were trained during the four year pilot period.[104] Moreover, of the 1,271 pilot-eligible children living with relatives, only 97 relatives had been trained under the pilot. Based on these data, when compared to the legislative standard of placing 75 percent of eligible children with a specially trained foster home or with a relative, the demonstration project did not meet the success standard set forth in the enabling statute.

AB 1741 YOUTH PILOT PROGRAM

Similar to many federal and State-funded programs, numerous health and human services programs are intended for services to children and families with common characteristics. Frequently, these programs target the same population with often overlapping goals, objectives and services. Nevertheless, most of the programs are "categorical" in that they have a specific definitions, defined populations and are governed by explicit programmatic and administrative requirements which allow little discretion on the flexible use of funds. Children suffering from abuse and neglect frequently have multiple needs including: health, mental health, education, developmental, juvenile delinquency and social services. As such, the common approach to addressing a child's multiple service needs is through individual categorical-type delivery systems. Many experts in the health and human services area contend that this categorical response often results in duplication of services, uncoordinated delivery systems from several public agencies, unmet or gaps in children or family services,

[102] The pilot period extended between January 1, 1990 to October 15, 1994.
[103] Of the pilot-eligible children, 33 percent were placed with a relative and 24 percent in a specially trained home.
[104] The department was unable to tell us how many of the 3,000 or 2,000 foster parents were currently providing foster care services at the time of the pilot and how many were new foster parents.

inefficient and sometimes conflicting services, as well as confusion and chaos to the service recipients.

Recognizing that uncoordinated delivery systems and the lack of funding flexibility was limiting the success of services to needy children and their families, in 1993, State legislation was adopted creating the Youth Pilot Program.[105] Intending to test new service delivery and funding approaches, as amended in later legislation, the Youth Pilot Program establishes a six-year pilot project in six counties authorizing the counties to explore various ways of improving services to high risk children and their families through local integration of services and other program innovations. The law authorized pilot counties to transfer funds for at least four services areas into a special fund and to use the funds to fund comprehensive, integrated services according to each county's strategic plan. In addition, the statute requires that counties submit annual reports, and conduct an interim and a final evaluation against the goals and objectives outlined in their plans. The law also requires that an independent organization conduct an assessment of the pilot program's effectiveness no later than 12 months after the completion of the sixth year following implementation of the program. (See Appendix I for the services areas included in this pilot program and the criteria for determining the success of the program.)

As the Governor's designee authorized in the legislation, the Health and Welfare Agency administers the pilot program and through a competitive process, selected Alameda, Contra Costa, Fresno, Marin, Placer and San Diego Counties as the six pilot counties. While each county had the option of implementing its program effective January 1, 1995, July 1, 1995 or January 1, 1996, all six counties selected the latest implementation date. The county board of supervisors for each county was required to establish a child and family interagency coordinating council comprised of, at a minimum, representatives from: the county or local school districts; juvenile justice court system; county, city and school officials responsible for funds or services included in the pilot program; service providers; service recipients; and public employee labor organizations. Although the legislation did not appropriate any new State funds for this program, the law invited local education agencies, cities and private, nonprofit agencies to allocate funds for purposes of this program Through the law, the Legislature stated its intent that the State and counties continue the commitment to maximize federal matching funds.

Currently, State agency teams are working with each county to carry out the strategic plans and the provisions of the program. However, according to the latest report relating to the program,[106] the State and pilot counties are experiencing substantial challenges and obstacles in attempting to implement the full blending of program funds intended by the legislation. The 1995 report stated that, because the county strategies relied heavily on federal funding, the most significant issue related to blending funds stemmed from the lack of federal funding

[105] Chapter 951, Statutes of 1993, AB 1741.
[106] California Health and Welfare Agency, Report to the California State Legislature Regarding Implementation of AB 1741 "Youth Pilot Program", December 31, 1995, page 6.

flexibility. To overcome this issue, in its Title IV-E waiver proposal to the federal government, the State is requesting greater latitude in the use of federal funds so that the counties can provide intensive, individualized services in a flexible manner.

Despite the funding obstacles, staff from the Health and Welfare Agency and the Department of Social Services stated that coordinated, collaborative efforts among county service agencies are working. As an example, they cited Placer County's efforts to develop a unified (case management) services record (USR). Working with State agency representatives, county staff proposed that a USR would enable the delivery of multiple services to be coordinated and integrated within a single record; be managed by one person or a team; promote the participation of family members; and reduce administrative inefficiencies. The work group found that the case management information needs for child welfare, health, mental health, and alcohol and drug services could be consolidated into a single unified services record without a waiver of existing State law or regulation.

State staff also cited Alameda County's Project Destiny as another pilot project with the potential of demonstrating an effective, collaborative strategy for intensive youth services. Project Destiny will provide 24-hour, comprehensive care to emotionally disturbed children and their families. With the goal of transitioning children back into the community with intensive in-home services, the project serves children from social services, mental health, special education and probation.

With an implementation date of January 1, 1996, the Youth Pilot Program will operate until December 31, 2001 with the evaluation report due by December 31, 2002. Nevertheless, agency staff suggested that if key elements of a county's program are determined to be effective in coordinating intensive children services, e.g., the unified services record or Project Destiny, the State could take steps to implement the activities on a wider scale prior to the final evaluation of the pilot program.

WRAPAROUND PROCESS

Abused and neglected children, suffering from severe emotional stress, often also experience multiple health and social difficulties. Commonly, service agencies attempt to meet the needs of these children with a variety of pre-designed service delivery programs each individually aimed at addressing a single need. However, many child welfare experts recognize that tailoring a child's service delivery plan based on several "categorical" service programs results in unsuccessful outcomes for the child and the family. Rather than fit a child's needs into these pre-designed programs, many experts say the service delivery systems should be tailored to meet the individualized needs of the child and the family. In response, child welfare officials have established "WrapAround" as one method of providing

intensive, individualized support services to children and families with multiple and complex needs.

WrapAround is not a program; instead WrapAround is process based on the philosophy that embodies two concepts: unconditional care and normalization. According to this philosophy, children best learn to become competent and productive adults if they live in, and learn from, a normal environment; that is, the children live with their own family or in family-like settings, and within their own community surrounded by their own culture. WrapAround involves hard work, no service time restrictions and an unconditional care commitment to providing necessary services to the child and family.

WrapAround focuses on family and community strengths and centers on positive aspects of the child and the family, not their weaknesses. Based on the holistic needs of the family and not the child only, individualized service plans are developed by a child and family team in partnership with trained private and public agency staff who can blend and shape community and public services to meet the family needs. Because of the unconditional care premise, no child is denied services and any service can be tailored to meet the needs of the child or family. The service plan is dynamic, changing to represent the needs of the family with services continuing until the child and family team determines that services are no longer needed.

The WrapAround philosophy has been embraced by Santa Clara County where the county Social Services Agency and Mental Health Department teamed with Eastfield Ming Quong, a private mental health center, to create a collaborative service effort, Program UPLIFT (Uniting Partners to Link and Invest in Families of Today). By providing intensive support services based on an individualized plans developed through WrapAround, program and county officials intend to demonstrate that high risk children with multiple, complex needs can be successfully moved from costly foster care group homes back to the community with their family or a family-like setting.

Effective July 26, 1996, Chapter 274, Statutes of 1996 (AB 2297), authorized Santa Clara County to redirect foster care funding to Program UPLIFT, giving program staff the funding flexibility necessary to purchase the services identified in the individualized service plans. Under the provisions of the statute, the program can serve no more than 125 child welfare cases each year until July 1, 2001. On or before the end of the enabling legislation, the county is required to submit a report to the Legislature that assesses the effectiveness of the program in reducing the level of out-of-home services and in reducing the average length of stay in out-of-home care. In addition, the report must compare the cost of placement and services for children in the program with the average cost of out-of-home placement for the same number of children.

Based on conversations with county, program and State representatives, the officials are encouraged by the results of the program to date. Prior to the State legislation, Program

UPLIFT had been serving children since 1994. In a July 1996 report,[107] program staff reported that the program had served 85 children and/or youth and that 75 percent (or 64) of the children were successfully maintained with their biological parents, in relative placement or in a community foster placement. Using private donations to the Eastfield Ming Quong Foundation and county social services and mental health dollars, program staff were able to leverage federal funds to gain the funding flexibility to purchase WrapAround services. However, with the recent State legislation, staff anticipate that the program will now better serve its clients.

FAMILY UNITY & FAMILY GROUP CONFERENCING MODELS

Other innovative approaches to developing child welfare service plans for children and their families are being reviewed and tested in California. These approaches include the Family Unity Model and the Family Group Conferencing Model.[108] Both models are based on the belief that families have strengths and, by focusing on family strengths and using a solution based approach to resolving concerns, a family can change to prevent or, at least, minimize out-of-home placement of children. The models also draw on the strengths and resources of the extended family as well as the strengths and resources of community agencies and individuals involved in a child's and family's lives. The primary goal of the models is to strengthen individual families in order to provide long-term solutions to family concerns while promoting safety of children.

Both models use family meetings to find and build a resource plan. One principal premise of both models is that the family is responsibility for creating a plan that will ensure their children's safety and keep the family together. By assuming responsibility for the plan, the family takes pride of ownership and is more committed to ensuring that the plan will work. The family meeting can include whomever the parent(s) wants involved in the process but they generally include extended family members such as grandparents, aunts, uncles, step-

[107] Eastfield Ming Quong, Program UPLIFT (**U**niting **P**artners to **L**ink and **I**nvest in **F**amilies of **T**oday), Services Report July 19, 1996, A Collaborative Services Effort of: Santa Clara County Social Services Agency, Department of Family and Children's Services, Santa Clara Valley Health and Hospital System, Department of Mental Health and Eastfield Ming Quong.

[108] Another model, the Family Decision Making Model, has been implemented in Stanislaus County. This model blends features of the Family Unity Model and the Family Group Conferencing Model while adding other local considerations. Similar to the WrapAround process, these models avoid referring to family problems and, instead, refer to family concerns. Advocates of these approaches say "problems" tend to imply blame or guilt that result in family member resistance, anxiety, fear, anger and an unwillingness to participate in the process. By focusing on family concerns, the strengths and values of all family members will bring the discussions to more meaningful and productive outcomes.

parent and non-custody parent, and godparents, members of a tribe or clan, and others concerned with the child's well-being.

Originating in Oregon, the Family Unity Model relies on a trained facilitator to assist the extended family in developing the family resource plan. Alternatively, the Family Group Conferencing Model, pioneered in New Zealand, relies on the extended family to independently develop the resource plan after receiving guidance and instruction from a trained facilitator. In the Family Unity Model, the facilitator remains in the room during the extended family discussion while the plan is developed. In the New Zealand Model, the facilitator leaves the room during the extended family deliberations and reviews the plan only after it is developed. The Family Unity Model has been used extensively in Oregon, and some counties in Iowa have begun to use it. By statute, children services agencies in the State of Idaho will soon begin using one form of family decision making in all its regions.

The Department of Social Services has conducted several workshops and training sessions throughout the State, inviting staff from county children services agencies, county juvenile courts, community service agencies and other concerned community members. Some counties including Santa Clara, San Diego and Stanislaus Counties have recently implemented the models into their child welfare activities. Other counties, such as Butte, Kings and San Luis Obispo have shown interest in the models and have conducted more intensive training beyond the two-day program offered by the department.[109]

These models have great appeal in that they minimize government intrusion into the lives of families and rely to a much greater extent upon the families to solve their child maltreatment problems. However, we have very little evidence of their effectiveness in minimizing recurrence of child maltreatment in families that have been reported to children protective services agencies. Even Oregon, which implemented the Family Unity Model several years ago had no data that could be used to evaluate the success of the model.

Currently, there are no formal evaluations plans for the models being piloted in California. Nevertheless, staff of the implementing counties are closely monitoring cases that have been referred for Family Unity Meetings or Family Group Conferencing. Based on preliminary information, staff report success in keeping families united or reunified if the child has been placed in out-of-home care. Many county staff enthusiastically support the models and believe this approach will enable families to successfully develop and carry out a plan to change the family that ensures safety of the children while minimizing or avoiding the juvenile court dependency process.

[109] One foster family agency, Aspira, which serves 28 California counties is developing a staff training program based on the Family Unity Model and plans to incorporate the concept into its case management plan development process.

TRANSITIONAL HOUSING PLACEMENT PILOT PROGRAM

To help prepare youths in out-of-home foster care for the time when they will transition to independent living, 1993 State legislation established the transitional housing placement program (THPP) which allows qualifying youth to live in an apartment under certain conditions.[110] In a three county pilot program, the statute requires that community care facilities participating in the program be licensed by the Department of Social Services to provide transitional housing placement services to youth who are at least 17 years old but not more than 18 years old, except under certain circumstances. Services under the THPP include:

(1) Programs in which one or more youth participants live in an apartment with an adult employee of the licensee.

(2) Programs in which a youth lives independently in an apartment rented or leased by the licensee located in a building in which one or more adult employees of the licensee reside and provide supervision.

(3) Programs in which a participant lives independently in an apartment rented or leased by a licensee under the supervision of the licensee with approval of the department.

Based on certification from the county welfare department, the community care facility's program must include: admissions and employment criteria; a training program; a monitoring plan; a contract between the youth participants and the facility; a monetary allowance schedule to enable youth to purchase food, utilities and other essentials; a participant's progress evaluation plan; and a linkage to the federal Job Training Program. By law, the cost for all participants in each county's program cannot exceed the aggregate cost of care and supervision for those youth had they not participated in the THPP. Although the enabling legislation limited the pilot program to three counties commencing in fiscal year 1994-95, the law also allows the department to approve the THPP in other counties if the department determines that the three pilot counties have successful outcomes.

Currently, only the three pilot counties are participating in the program: Contra Costa, Los Angeles and Stanislaus Counties and, to date, only Stanislaus County has fully implemented the program. According to Stanislaus County staff, the county serves as the project "licensee" and five youths have received services through the program with three of the youths successfully completing the program. Under the county's program, the youths live alone or with other foster youths and the county monitors their activities with a combination

[110] Chapter 799, Statues of 1993 (AB 1198) established Section 16522 et. seq. of the Welfare and Institutions Code.

of county and volunteer staff. The county noted that one limiting experience was finding available apartments for youths within the school district where the youths currently attend school. Nevertheless, the county staff are encouraged with the project's results and will be increasing the number of youths in the project within the near future.

HOME VISITING PROGRAMS

The State of California's current participation in home visitation programs for abused and neglected children and their families centers around two efforts: (1) ten early in-home family support services projects; and (2) the San Diego Healthy Families Program (HFP). The ten early in-home projects are located in seven urban and three rural sites throughout the State. Beginning in 1994-95, each project received $150,000 per year for three years from a combination of funds from the federal Child Abuse and Prevention Treatment Act (CAPTA), the State Child Abuse Prevention Intervention and Treatment Act (CAPIT) and the State Children's Trust Fund. Each project's design was based on local community needs but intended to provide support services to families assessed to be at high risk for abusing or neglecting their children from birth to five-years of age. All projects are currently operating in their final funding period unless local governments decide to continue the projects using other funding sources. No overall evaluation or assessment of project outcomes is planned; however, individual projects may conduct independent reviews.

The San Diego HFP is a five-year clinical research project funded through a joint partnership of the Wellness Foundation, the California Department of Social Services and the Stuart Foundation. The program is patterned after the Healthy Families America Model as it was implemented in Hawaii's Healthy Start Program. Similar to the Hawaii program, HFP uses paraprofessional home visitors but will also include support groups and a child developmental specialist which were not used in Hawaii's model. Under a $3.7 million contract with the Center for Child Protection at Children's Hospital of San Diego, the program will identify 500 at-risk families and, using a randomly assigned 'control group/experimental group' research design, the program will serve and track its clients for three years. The project's study design addresses seven specific aims:

(1) to develop an "optimal" model of the Healthy Families America home visitation intervention;
(2) to test whether implementation of this "optimal" model in a California setting results in improved child health and development outcomes, improved maternal life course outcomes, reduced risk for child abuse and neglect, reduced incidence of child abuse and neglect, families more effectively tied into other needed services in the community;
(3) to determine what cost-benefit relationship is derived from this "optimal" model;
(4) to develop what factors predict early disengagement from the program;

(5) to develop what outcomes result from early disengagement from the program;
(6) to develop the critical features in the professional supervision of paraprofessional home visitors; and
(7) to develop what is perceived by the client and/or the home visitor to be the critical elements of the client family/home visitor relationship.

Clients for the San Diego HFP were recruited during 1996 from the Mary Birch Hospital of the Sharp HealthCare system where over 9,000 babies are born each year. The program targeted high-risk families by reviewing computerized and clinical records. Potential clients were then interviewed by trained interviewers using a "Family Stress Checklist." High-risk families were randomly assigned to the control or experimental group if they consented to participation in the program.

The clinical evaluation of the HFP is being performed by the Child and Family Research Group, an inter-disciplinary consortium of researchers from Children's Hospital, San Diego State University, the University of California at San Diego and the University of San Diego. The final evaluation report is not expected until the year 2000.

JUVENILE CRIME PREVENTION DEMONSTRATION PROGRAM

Responding to growing concerns about criminal acts committed by children, through the 1994-95 May Revise, the Governor established the Juvenile Crime Prevention Initiative. The initiative directed the Department of Social Services to design a program to demonstrate how an array of services will impact on the health of a community and reduce juvenile crime. Funded annually for an anticipated four and one-half years, the program allocates nearly $10 million a year among twelve project sites. Due to startup delays, all twelve projects commenced operation on January 1, 1996. As of June 1996, approximately 125 subcontractors were providing program services to about 1,400 families and 3,000 children.

With six sites located in Northern California and six in Southern California, the twelve project sites were selected on a statewide competitive bid process. Each project was required to establish a Community Oversight Council comprised of community members, including public and private agencies staff, business and religious leaders, consumers and parents. In addition, each project also involves a strong collaborative effort among community service providers with one provider serving as the lead agency. Also, each project is centered around a Family Resource Center which provides services intended to assist in the prevention of juvenile crime. The components of each project include:[111]

[111] Governor's Budget Summary, 1995-96, page 157.

- Families and School Together -- a highly structured eight week drug and alcohol abuse prevention program for at-risk children and families including two years of follow-up activities.

- Mothers and Sons Program -- a program targeting single mothers and their sons aged 10 to 14 who have had school suspensions or been involved in gangs, bullying, or minor vandalism. The focus of the program is on family responsibility and community involvement, and would include family preservation services, classroom and group training, and family support networks.

- First Offenders and Family Preservation -- a program to provide intensive family counseling and social work services for a three-to-four month period, with follow-up and supportive services for an additional six months.

- After School Program -- a program to provide recreational and educational services for youths and to provide them with an opportunity to perform community services, as well as providing respite time to parents. The program operates in partnership with existing community programs.

Through funds made available by the Stuart Foundation, the department has planned and selected a contractor to perform an independent evaluation of the juvenile crime prevention program.[112] The evaluation contractor is working with each project to select indicators for measuring the project's success. A report on the planning and implementation process is anticipated by March 1997. Thereafter, quarterly reports will be prepared by the evaluator and an annual report is required within two months of the end of each project year.

TITLE IV-E WAIVER PROJECT

In reaction to concerns about children languishing in foster care, the 1980 federal Adoption Assistance and Child Welfare Act (P.L. 96-272) directed states to make reasonable efforts to keep families together by preventing out-of-home placement and reuniting children already in out-of-home care with their families. To carry out the purpose of the Act, public child welfare agencies have attempted to offer an array of services aimed at preserving or reunifying the family unit only to encounter funding barriers that limit or inhibit the agency's ability to deliver the services. In a 1993 report by the United State General Accounting Office (GAO),[113] the authors stated that "The current federal system for financing child welfare funding programs offers little incentive for states to provide services designed to achieve the 1980 legislative goals of keeping families together and averting the need for

[112] Philliber Research Associates is performing the evaluation of the juvenile crime prevention projects.
[113] U. S. Gerneral Accounting Office, FOSTER CARE: Services to Prevent Out-of-Home Placements Are Limited by Funding Barriers, June 1993, GAO/HRD-93-76.

foster care." The authors based their findings, in part, by studying strategies for delivering family preservation services in three states: California, Michigan and New York.

The GAO's finding was not a surprise to California child welfare officials where State and local officials had already recognized the restricted uses of federal funds allocated to the State through Titles IV-B and IV-E of the Social Security Act. Title IV-B provides federal matching grants to the State for child welfare services costs including family preservation programs, but the federal funds are capped. In addition, while Title IV-E is an uncapped entitlement for AFDC eligible foster care children to maintain out-of-home placement, the funds are restricted to such costs as food, shelter, and administration and training for agency staff.[114] Moreover, as reported by the GAO, Title IV-B funds have not increased at the rate of foster care expenditures or at a rate necessary to meet the needs for child welfare services.[115]

To address the growing concern over the lack of adequate funding to meet the needs of child welfare services, in November 1996, the State Department of Social Services (DSS) submitted a revised Child Welfare Waiver Demonstration Proposal to the United States Department of Health and Human Services (DHHS). Working collaboratively with the California County Welfare Directors Association, DSS requested a waiver on the restricted use of Title IV-E funds so that the funds could be used in innovative and flexible ways. Designed around three components, the waiver proposes to promote permanency for children and families, to divert children from the juvenile court system and to facilitate movement of children to less restricted levels of care at no additional costs to the federal, State or county governments. The department intents to carry out the proposal on a pilot basis in not more than 27 county projects across the three components during the first year of operation. With a planned start date of July 1, 1997, the department proposes to operate each component for a five-year period. The actual start date of each component may vary depending on the need to change existing State statute or regulation to conform with an approved waiver proposal.

Extended Voluntary Component

Current federal law allows states to seek reimbursement for out-of-home costs for eligible children who have been voluntarily placed in foster care by the parent(s) or guardian(s) without involvement of the juvenile court system. However, the law limits federal payments for these foster care costs to six months. To extend payment beyond that period, court dependency action on the child must occur prior to the 180th day.

[114] The federal government reimburses the State for a portion (50 percent) of the State's eligible foster care costs.
[115] In the 1993 GAO report, the authors stated that the Title IV-E to Title IV-B expenditure ratio was 2:1 in 1981 and 8:1 in 1992. Further the report states that between 1981 and 1992, Title IV-B funding increased 67 percent but IV-E expenditures increased 616 percent.

Many child welfare officials, including juvenile court judges believe that more children in voluntary placement can be successfully reunified with their families if the out-of-home placement can continue while the child and/or family complete support services treatment. These officials believe an unnecessary early intervention by the court system can interfere with timely reunification efforts because the dependency process can be adversarial, can traumatize a child, and can put the parent(s) in disagreement with court ordered requirements. Further, they say that the delays caused by contested cases are not always due to the severity of the abuse or neglect incident.

Under the waiver proposal, federal eligibility for voluntary placements would be extended from six months to twelve months. To be eligible for participation in this component, the department will require participating counties to develop and implement a process which ensures that a second level supervisor, or an administrative review board or its equivalent has reviewed and approved the extension. The counties would then have an additional 180 days (a total of 360 days) to return a child to the family or to establish court dependency and keep the child in out-of-home care.

Kinship Permanence Component

Earlier, we reported that nearly forty-five percent of California's foster children are in out-of home-placement with a relative. Many children are in stable, long-term placement with relatives who are committed to preserving the family relationship and who have demonstrated a willingness to assume substantial responsibility for the child's development. Often times, however, the relative, generally a grandparent, has limited income and must rely on the foster care payment to provide the child with adequate food and shelter.

Competing with long-term kinship placement, State policy requires that if a child cannot be returned home within 18 months, the child be moved towards permanent placement. By law, county placement officials are required to first consider the adaptability of the child and, then, guardianship before considering long-term foster care. However, if a relative becomes the legal guardian of a federally eligible child through adoption or guardianship, the child generally will lose his or her eligibility for federal foster care benefits.[116] Faced with this loss of funding support, many relatives are reluctant to become a foster child's legal guardian.

California's waiver proposal would establish a pilot project to test and evaluate an alternative means of supporting long-term, stable, relative care placements. Based on a "long-term kinship agreement" between the relative care provider and the participating county, the

[116] While the child may lose federal foster care benefits, the child could be eligible for Aid to Families with Dependent Children (AFDC); however, the monetary amount of this aid is less than the foster care payment. Because details of the Administration's proposed California Temporary Assistance Program (CalTap) are still under discussion, we are uncertain how the recently enacted federal legislation that replaced the AFDC program with the Temporary Assistance for Needy Families (TANF) Program will impact these benefits.

relative will be given custody or guardianship of the child to ensure that the caretaker has adequate legal protection and consent authority. Once the agreement is final, the court dependency action will be dismissed but the child will continue to receive the basic foster care payment rate and be eligible for Medi-Cal/Medicaid. Moreover, although the child's court dependency has been dismissed, the child will remain eligible for the Independent Living Program once the child reaches the age of 16.

Services Component

As noted above, the uncapped Title IV-E foster care funds are based on actual costs but their use is restricted and can be used only as reimbursement for out-of-home board and care. These funds cannot be used for any other program service. While Title IV-B funds can be used for other program services, they are capped and the current level of funding is insufficient to meet the needs of children and their families who are involved in the child welfare system. The inadequate funding level and the lack of funding flexibility have seriously undermined the ability of child welfare officials to carry out the goals of the federal Adoption Assistance and Child Welfare Act. These restrictions serve as a disincentive to removing children from foster care and go against the goal of the Act to preserving the family unit.

In seeking a waiver to Title IV-E funding restrictions, the department intends to allow pilot counties to provide intensive, individualized services in a flexible and innovative manner.[117] By targeting selected children and families and providing them with needed services, more children will be able to remain at home with their families or placed in a lower level of care than would otherwise be possible. The department will measure whether the counties can achieve better results for children and families through the options afforded the counties under this waiver.

Evaluating The Waiver Components

Federal law requires that an independent evaluation be performed on any waiver of federal requirements on programs funded under the Social Security Act In compliance with the requirement, the department's proposal sets forth a methodology for evaluating the successes of the pilot projects in achieving the desired outcomes for each component and ensuring that the innovative approaches protect child safety and are efficient. (Appendix J contains a listing of the outcome measures included in the waiver.) The department's methodology includes three evaluation elements: an outcome evaluation, a process evaluation and a formative evaluation.

[117] Some of the innovative approaches suggested in the State's waiver proposal include WrapAround, family preservation and support services, the Family Unity Model, and the AB 1741 Youth Pilot Program. These service approaches were discussed earlier in this chapter.

The outcome evaluation will be based on a quasi-experimental design which will compare a county's performance under the waiver against its performance prior to the waiver . Also, the design will permit a comparison of waiver counties or subjects against comparable non-waiver counties or subjects.[118] When analyzing outcome data, the evaluation contractor expects to distinguish the outcomes by four different age groups, by four primary racial/ethnic groups and by type of foster care placement; i.e., kinship care, non-kinship foster care, treatment foster family agencies and group care. Moreover, if a county seeks to implement more than one component of the waiver, the county will be required to demonstrate how it will ensure that services of one component do not impact services of another component.

The process evaluation is intended to determine how the innovative approaches were actually implemented, to clarify which service recipients received the most benefits and satisfaction, and to determine how services could be improved. Information will be collected from six population groups: (1) child welfare line workers; (2) supervisors and public administrators; (3) out-of-home care providers; (4) private child welfare service providers; (5) older children; and (6) biological parents. In addition, information will be gathered from intake data collection as well as possible exit data collection sources.

The formative evaluation element will be an ongoing process. Through coordinated meetings and workshops with participating counties and continuous feedback from the evaluation contractor, the counties will share information and receive prompt information regarding their achievement of the waiver goals.

The evaluation design includes a limit on the number of counties to be included in each component's evaluation: the extended voluntary component will include ten counties, the kinship component will be limited to four counties, and the services component will be limited to twelve counties. However, the design does allow for the additional counties to be included in the evaluations following the first year of the waiver.

The department anticipates establishing an interagency agreement with the Child Welfare Research Center of the University of California at Berkeley to conduct the required evaluation. The waiver proposal does not state whether interim reports on the waiver will be prepared by the department and/or the evaluation contractor or if a single evaluation report will be forth coming at the conclusion of the five-year waiver.

[118] According to the waiver proposal, while a quasi-experimental design generally is less favorable than an experimental evaluation design, recent advances in statistical methods enable evaluators to better control for potential bias resulting from non-random sampling.

EFFECTIVENESS OF PILOT PROJECTS, INNOVATIVE APPROACHES AND SERVICES

In the prior sections, we discussed several pilot projects and innovative service approaches that have recently become part of California's child welfare system. With the exception of the Options for Recovery Project and some descriptive information about other projects and approaches, we found little information that documents the successes of these efforts. As a rule, these efforts have only begun within the past two to three years and effectiveness data have not been collected. In addition, as we visited county children services agencies and some of the local child welfare services, we asked county officials for reports that show the effectiveness of any program or project operating in their county. While many officials spoke enthusiastically about projects or service approaches in their counties, they acknowledged that generally the only data available are process-related. In addition, they noted that few projects contained measurable outcomes as part of the project design. We did have occasion to observe some projects and talk to clients. For the most part, clients also were enthusiastic about the services and spoke of the beneficial changes to their family lives.

As our next step to determine the effectiveness of California's child welfare system, we attempted to identify research showing the effectiveness of specific services provided, or required, by county children services agencies or the courts for parents who have abused or neglected their children. Despite performing a thorough literature search and contacting many child welfare researchers throughout the country, we found very few studies that assessed the effectiveness of those services in reducing incidents of child maltreatment or improving family functioning. We found only two studies we believe are relevant to child welfare programs in California. One study addresses the effectiveness of parenting training and counseling in reducing child maltreatment, and the other study addresses the effectiveness of substance abuse treatment in reducing child maltreatment.

The first study, an evaluation of 19 separate projects located throughout the United States, measured the number of maltreatment incidents committed by parents during the treatment period and attempted to measure parents' propensity toward future child maltreatment, as determined by clinicians' judgment, and assessed the effectiveness of various counseling and parent training services in affecting those outcomes.[119] Although the findings vary significantly by the type of child maltreatment leading to involvement with child protective services agencies, the study generally found that group counseling was the only type of counseling that was statistically significant in reducing the clients' propensity toward maltreatment and the number of recurrences of child maltreatment. Individual counseling and family counseling did not produce statistically significant reductions in either outcome measure, but the author notes that family counseling was successful for families whose maltreatment took the form of neglect in the projects that centered their interventions on family therapy. Also, parenting education was not statistically significant in explaining either

[119] Daro, D., Confronting Child Abuse, New York: Free Press, 1988

measure of maltreatment. As the author noted, "projects were generally more successful in improving their clients' overall functioning than they were in reducing a client's likelihood for future maltreatment or avoiding new abusive episodes while the family was in treatment."[120]

The second study is an evaluation of seven perinatal substance abuse programs that operated in California between 1991 and 1993.[121] The programs targeted pregnant substance abusers, substance-abusing caretakers of infants and toddlers, and biological parents of infants or toddlers who exhibited signs of substance exposure. Two-thirds of the parents received parenting training and almost 90 percent received substance abuse treatment. The evaluation found that 22 percent of the children of parents in the program were abused or neglected between the beginning of treatment and 12 months after treatment ended. The evaluation also found that 5 percent of the children who were not already in foster care when services began were placed in foster care within 12 months after treatment ended. Unfortunately, the evaluation did not employ a comparison group, so it is impossible to say whether the number of cases of child abuse and neglect, or the number of foster care placements, would have been different in the absence of the program. Furthermore, the evaluation made no attempt to discern the separate impacts on child maltreatment of the different types of services that were provided to the clients.

The perinatal substance abuse program evaluation also found that 75 percent of the clients were rated by clinicians as making progress toward their goals and 40 percent were judged as having stopped using drugs during treatment. However, less than 15 percent of the clients completed their treatment, and the follow-up period was very short. Consequently, it is not known what the longer-term impact of the services were.

Because of the paucity of research on the effectiveness of substance abuse treatment programs on child maltreatment, we reviewed research from an extensive body of literature dealing with substance abuse treatment programs for the general population, some of which may be applicable to child welfare programs. Among the findings of that body of research are:[122]

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[120] Ibid., p. 107.

[121] Walter R. McDonald & Associates, Inc., Perinatal Substance Abuse Programs Evaluation, Final Report, Sacramento: Walter R. McDonald & Associates, Inc., October 1994.

[122] Most of the findings presented here are from two major drug abuse treatment research efforts sponsored by the federal government during the 1970's and 1980's. Many findings were subsequently reconfirmed by several smaller studies. The studies, known familiarly as the DARP (Drug Abuse Reporting Program) study and TOPS (Treatment Outcome Prospective Study) were published in Simpson, D., and Sells, S., Evaluation of Drug Abuse Treatment Effectiveness: Summary of the DARP Follow-up Research, Washington, D.C.: U.S. Government Printing Office, 1983; U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration, Addiction Careers: Summary of Studies Based on the DARP 12-Year Followup, Washington, D.C.: U.S. Government Printing Office, 1986; Simpson, D., Joe, G., Lehman, W., and Sells, S., "Addiction Careers: Etiology, Treatment, and 12-Year Follow-up Procedures," Journal of Drug Issues, 16 (1), pp. 107-122; and Hubbard, R., Marsden, M., Rachal, J., Harwood, H., Cavanaugh, E., and Ginzburg, H., Drug Abuse Treatment: A National Study of Effectiveness, Chapel Hill, NC: University of North Carolina Press, 1989. Summaries of those studies are presented in Rutgers Center of Alcohol Studies, Socioeconomic Evaluations of

- Between half and three quarters of the patients drop out of most drug treatment programs without completing treatment. The dropout rate for most programs tends to be almost 75 percent, whereas methadone maintenance programs tend to have dropout rates of about 50 percent.

- More than half of the patients treated by inpatient or outpatient treatment programs drop out within the first three months. The retention rate for methadone treatment programs tends to be better, with less than 30 percent dropping out within three months.

- By far, the most significant factor affecting treated drug users' subsequent use of drugs and their subsequent employment history is the amount of time they spend in treatment.

- With few exceptions, where the treatment resulted in a reduction in drug usage or a reduction in criminal activity, these favorable effects were achieved within a relatively short period (e.g., two months) after admission. However, changes in productive activities (e.g., employment) typically were not observed until later (at least three to four months after admission).

- For patients who remain in treatment for at least three months (six to twelve months in some studies), treatment results in substantial and statistically significant reductions in drug use, even if abstinence is not achieved.

- Many patients, estimated by one study to be approximately 60 percent of those receiving treatment, are readmitted to treatment at some point during an extended follow-up period (three to five-years). The studies that employ longer follow-up periods generally, but not always, find a higher percentage of recidivism. One study found that the average patient who was treated at an outpatient program experienced 2.4 readmissions during a 12-year follow-up period, and the average patient treated at an inpatient program experienced 3.6 readmissions during the follow-up period.

- A significant percentage of patients who completed treatment programs of more than three months were abstinent 12 months after their first treatment. For the best-known studies, which evaluated treatment programs lasting six months or longer, the abstinence rate for cocaine users completing treatment was estimated at 40 to 50 percent. For heroin users, it was estimated to be 25 to 40 percent. However, other studies have found that the number of patients remaining abstinent tends to decline over time. Furthermore, one study, which found that almost 80 percent of the former heroin users claimed to have been free of heroin use during the prior year, also found that those clients increased their consumption of alcohol and marijuana. For most patient categories, the number of

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Addictions Treatment: Executive Summary, Washington, D.C.: The President's Commission on Model State Drug Laws, December 1993, pp. 6-7 to 6-30.

patients using alcohol and marijuana daily at the end of the five-year follow-up period was approximately twice the percentage using those substances daily before treatment began. It is also unclear that abstinence rates as high as 40 or 50 percent apply to all treatment programs. One study found an abstinence rate of only 15 percent for cocaine treatment programs that were as short as 21 days.[123]

The problem with applying any of these findings to programs designed to prevent child abuse and neglect is that there is no theoretical or practical basis for establishing a threshold for the frequency or amount of substance abuse above which a parent becomes a high risk for child maltreatment. Study after study of substance abuse treatment has shown abstinence rates of less than 50 percent, even a relatively short time (12 months) after treatment. Therefore, children services agencies can hope for, at best, only a reduction in the frequency of substance abuse or a reduction in the amount of substances consumed by substance-abusing parents. But is reduced use sufficient to provide a safe environment for a child who is being returned home? We know of no research that addresses this issue. Furthermore, there is research that suggests that changes in drug consumption, including the elimination of drug use, are not correlated with other behavioral outcomes, such as psychological functioning and family relationships.[124] *We believe this points to the need for research on the long-term impact of substance abuse treatment programs on child maltreatment before substantial amounts of State funds are committed for that purpose.*

[123] Khalsa, H., and Anglin, M., "Treatment Effectiveness for Cocaine Abuse," in Cocaine Today and Its Effects on the Individual and Society (United Nations Interregional Crime and Research Institute Monograph, UNICRI Pub. No. 44), Rome: UNICRI, 1991, pp. 89-98.

[124] McLellan, A., Luborsky, L., Woody, G., and O'Brien, C., "The Generality of Benefits from Alcohol and Drug Abuse Treatments," in L. Harris (Ed.), Problems of Drug Dependence: Proceedings of the 42nd Annual Scientific Meeting, The Committee on Problems of Drug Dependence, Inc., (National Institute on Drug Abuse Research Monograph No. 34), Washington, D.C.: U.S. Government Printing Office, 1981, pp. 373-379.

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CHAPTER 7
OTHER ISSUES

INTRODUCTION

As we reviewed the literature, and talked to child welfare experts and social researchers throughout California and the nation, we were informed about policies, procedures and operations that influence the delivery of effective child welfare services. For example, the manner in which children services agencies identify and target services through risk assessment has a bearing on the outcome of services. Similarly, adequate training of county workers and policies of juvenile courts, in part, influence the delivery of services. We also learned that several factors contribute to the inability to determine effectiveness of child welfare programs, including: the absences of historical as well as current program data; reporting and definition differences among jurisdictions; variations among similarly named programs; and outside factors affecting the target population. We review these factors in the following sections.

In addition, we were told that the high cost of conducting rigorous evaluations often imposes a limiting effect on evaluation efforts. Frequently, the full impact of child welfare services is not known for several years after the services are initiated and/or terminated. Tracking children and families for three to five-years to measure the impact of services can be very costly. Also, many child welfare officials are reluctant to establish a rigorous evaluation design that uses "treatment" and "control" groups. In this type of evaluation, the control group consists of clients who are similar to clients in the treatment group, but do not receive the (program) services provided to the treatment group. The evaluation then measures the differences in outcomes between the two groups. Some officials are apprehensive about withholding needed services to children or families solely for evaluation purposes.

RISK ASSESSMENT

One possible barrier to program effectiveness is the lack of good risk assessment instruments and processes for determining the risk of children being maltreated by their parents or other caregivers.

All children services agencies engage in risk assessment. Upon substantiating a report of child maltreatment, children services agencies must decide whether to remove a child from his/her home. At this point, a judgment is made about the likelihood of reabuse or reneglect if the child is left at home. Similarly, when children services agencies consider whether to return a child home from foster care, a judgment is made about the likelihood of recurrence of abuse or neglect after the child returns home. Although these judgments may be subjective and based wholly on the intuition and experience of the caseworker and the caseworker's supervisor, the agencies are engaging in risk assessment in making both decisions.

Since 1980, there has been a movement among child welfare organizations and advocates to formalize the risk assessment process. In 1982, Illinois became the first state to adopt a formal statewide risk assessment instrument. Currently, at least 42 states have adopted some form of risk assessment instrument.[125]

Why use formal risk assessment instruments? As one child welfare expert notes:

> "Unfortunately, the literature on human information processing and decision making strongly suggests that personal judgment is often influenced by contextual factors such as the representativeness of the case, the availability or vividness of information, and the presumed relevance of the available information to the decision being made. Without guidance [in the form of risk assessment instruments], these subjective influences can easily result in decisions that do not accurately reflect the likelihood of future child maltreatment in a given case or that are not consistent across different cases involving similar circumstances and client populations."[126]

Some observers believe that the use of risk assessment instruments has occurred in part because of changes in laws that have required children services agencies to demonstrate the presence or risk of a particular harm to a child before removing the child, and in part because children services agencies needed a way to prioritize cases as a way of dealing with large increases in reports of abuse and neglect.[127]

Risk assessment instruments have three basic purposes: (1) predicting recurrence of abuse or neglect and the potential for future harm if the child is left with the caretaker; (2) helping caseworkers more effectively target services by identifying the most important risk factors present; and (3) helping children services agencies prioritize cases, thereby allowing caseworkers to spend more time with the highest-risk families.

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[125] English, D., "The Promise and Reality of Risk Assessment," Protecting Children, 12(2), 1966, p. 9.
[126] Cicchinelli, L., "Risk Assessment: Expectations and Realities," The APSAC Advisor, 8(4), 1995, p. 3.
[127] Wald, M., and Woolverton, M., "Risk Assessment: The Emperor's New Clothes?," Child Welfare, 69(6), 1990, note 3; and Schene, P., "The Risk Assessment Roundtables: A Ten-Year Perspective ," Protecting Children, 12(2), 1966, p. 5.

Some child welfare experts argue that basing risk assessment on the probability of recurrence of child maltreatment is short-sighted, that this may result in placing too much weight on low-risk cases. They argue that, to be effective, risk assessment instruments should be highly reliable not only in predicting the likelihood of recurrence but also in predicting the severity of future maltreatment. In addition, the predictions should take into consideration the services that may be available to mitigate the risks.

We found no evidence of risk assessment instruments in use today where both the risk of recurrence and the severity of future maltreatment are assessed, and we found no evidence of instruments in which services are taken into consideration in predicting risk. We believe the failure of risk assessment instruments to predict severity is a shortcoming that needs to be addressed. However, we believe the failure of the instruments to take services into account is not a concern. In states where risk assessment instruments are being used today, a case plan typically is developed soon after risk is assessed. Case planning includes determining which services are required by the family to reduce the likelihood of recurrence of maltreatment. In formulating case plans, child protective services workers make decisions on whether to remove children from their homes based not only on the families' risk assessment scores but on services that are available to reduce that risk

There are several, widely varying risk assessment instruments in use today. Most of them are "consensus-based" instruments, i.e., they are based on expert opinions about factors thought to be correlated with child abuse and neglect. Recently, however, consensus-based instruments have been criticized because of the lack of research on their predictive abilities, because children services agency staff have inadequate skills and instruments to use them properly, and because they are being used for purposes other than those for which they were designed.[128]

None of the consensus-based instruments has been tested empirically to demonstrate that the factors on which they are based are statistically significant in predicting child maltreatment. The advocates of some consensus-based models argue that some of the factors included in the models have been tested empirically and shown to be statistically significant. Although to some extent this is true, the results of those analyses suggest that relatively few factors used in the models have been consistently shown to be statistically significant in predicting child maltreatment.[129] Moreover, consensus-based models generally use a large number of factors

[128] Wald and Woolverton, ibid., pp. 483-511; English, D.J., Aubin, D.W., Fine, D, and Pecora, P., Improving the Accuracy and Cultural Sensitivity of Risk Assessment in Child Abuse and Neglect Cases, Washington, D.C.: National Center on Child Abuse and Neglect, February 1993, pp. 1-4; and Curran, T., "Legal Issues in the Use of CPS Risk Assessment Instruments," The APSAC Advisor, 8(4), 1995, p. 16.

[129] For example, see Bath, H.I., Richey, C.A., and Haapala, D.A., "Child Age and Outcome Correlates in Intensive Family Preservation Services," Children and Youth Services Review, 14, 1992, pp. 389-406; English, D., et al., ibid., pp. 3-10 to 3-25; and McDonald, T. and Marks, J., "A Review of Risk Factors Assessed in Child Protective Services," Social Service Review, March 1991, pp. 112-132.

(one model uses more than 40 factors), many of which are likely to be highly correlated with each other. Consequently, the validity of those analyses often is questionable.[130]

Recently, some state and county children services agencies have attempted to improve the predictive validity of their risk assessment processes by adopting empirically-based risk assessment instruments.[131] Leading the movement to empirically-based instruments is the Children's Research Center of the National Council on Crime and Delinquency (NCCD), an organization that has developed risk assessment instruments for use by criminal justice agencies in determining the risk that jail and prison inmates present to themselves, to guards and to the public. The NCCD has developed empirically-based child welfare risk assessment instruments for the states of Alaska, Michigan, Oklahoma, Rhode Island, and Wisconsin and currently is working with the States of Georgia, New Mexico and New York. The NCCD strongly believes that research in several fields has demonstrated that empirically-based instruments are better than clinical judgment at predicting human behavior and cite a 1989 article in the journal, *Science*, to back up those views.[132] Despite widespread skepticism among child welfare practitioners we interviewed, the small amount of research comparing child maltreatment risk assessment instruments seems to support those views.[133]

The State of Michigan's Department of Social Services is one of the state agencies that has contracted with NCCD to develop an empirically-based risk assessment instrument. Twelve months after implementation, Michigan found that the pilot counties that implemented the new risk assessment instrument categorized more emergency response cases as "low-risk"

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[130] When several variables that are highly correlated are included as independent variables in a regression analysis, "multicollinearity" is a problem. Depending on the extent of the multicollinearity, regression analysis and other statistical tools may be unreliable for determining statistical significance of independent variables. See, for example, Morrow-Howell, N., "The M Word: Multicollinearity in Multiple Regression," Social Work Research, 18(4), December 1994, pp. 247-251.

[131] In one case, adoption of an empirically-based instrument was even mandated by the state legislature. In Illinois, the state legislature required the Illinois State Department of Children and Family Services to replace its consensus-based risk assessment instrument with a validated (i.e., empirically-based) instrument. As a first step, the department has adopted an instrument that was developed by the State of New York. Ironically, the State of New York is considering modifying or abandoning its risk assessment instrument in favor of one that is empirically based.

[132] Dawes, R.M., Faust, D., and Meehl, P., "Clinical Versus Actuarial Judgment," Science, 243, March 31, 1989, pp. 1668-1673.

[133] Baird, C., Wagner, D., Caskey, R., and Neuenfeldt, D., The Michigan Department of Social Services Structured Decision Making System: An Evaluation of Its Impact on Child Protective Services, Madison, WI: Children's Research Center, National Council on Crime and Delinquency, March 1995; Johnson, W and L'Esperance, J., "Predicting the Recurrence of Child Abuse," Social Work Research & Abstracts, 20(2), Summer 1984, pp. 21-26; Johnson, W., "Accuracy, Efficiency, and Research Standards for Risk Assessment Systems," Summary of Highlights: Fourth National Roundtable on CPS Risk Assessment, Englewood, Colorado: American Human Association, 1991; and American Humane Association, The National Resource Center on Child Abuse and Neglect, Risk Assessment Technical Brief, Englewood, CO: American Humane Association, May 31, 1994.

and closed them without action than did the counties that had not implemented the instrument. Based on the research of the NCCD, it appears that Michigan children services agencies had been over-classifying ten to fifteen percent of their low- and moderate-risk cases as high-risk before they adopted a risk assessment instrument that was based on statistically valid risk factors. Although research in this area still is sparse, this seems to be a common theme in some of the research we encountered.[134]

Despite closing more cases as low-risk, Michigan's pilot counties experienced fewer recurrences of child abuse and neglect among cases they reviewed and closed than did the counties that did not implement the new instrument. The pilot counties also had fewer out-of-home placements and child injuries than did the other counties. Michigan and NCCD attribute the latter results to the success of the risk assessment instrument in predicting recurrence of abuse and neglect and to the pilot counties' providing more services to families who were determined to be high risk.[135]

This points to another advantage of empirically-based risk assessment instruments, viz., allowing child welfare agencies to redirect scarce resources to families most in need. Currently, high-risk and low-risk cases tend to be treated alike by children services agencies, with services being provided both to families that need them and families that could get by without them. Consequently, available resources are diluted and not applied efficiently and effectively. When the State of Michigan implemented the new model in the pilot counties, it found both that caseworkers were devoting more time to high-risk cases than before the model was used and that the percentage of high-risk cases receiving services (parenting education, substance abuse treatment, family counseling and mental health services) was substantially higher in the pilot counties than in the counties that had not implemented the model.[136] Now that its new risk assessment instrument has been implemented statewide, the state is optimistic that it will be able to show that a significant amount of resources have been redirected from low-risk cases to high-risk cases once its workload and accounting system has been completed.

It is worth noting that even where empirically validated models are used, the decision to remove a child from his/her home always is a judgment call based on whether services can be provided in sufficient intensity to reduce the risk of reabuse or neglect to an acceptable level. In fact, one of the benefits of risk assessment instruments in general is that they force caseworkers to systematically identify areas in the family environment and background that contain risks and to tailor services accordingly. The advantage empirically-based risk assessment instruments have over consensus-based instruments is their ability to more accurately distinguish the low- and moderate-risk cases from the high-risk cases.

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[134] Similar results were found in Rhode Island, according to NCCD staff and Rhode Island staff with whom we spoke. Similar results also were noted in Johnson and L'Esperance, ibid., p. 25, and in Daro (1996), op.cit., pp. 51-55.

[135] Baird, et al., op.cit., "Highlights."

[136] Ibid., pp. 8-9.

Despite the clear programmatic and fiscal benefits of empirically-based instruments, NCCD and others caution that the predictive quality of the risk assessment instrument alone is not sufficient to produce the results obtained in the pilot counties in Michigan. Equally important is implementation. Several experts, including those who have studied the implementation of risk assessment instruments by child welfare agencies, have noted the difficulties presented by implementation. For example, several of them found that even after a new risk assessment instrument is officially adopted by the state, caseworkers continue to assess risks as they have always done and fill out the assessment instrument merely to obtain the result they desire.[137] We heard similar assessments from many of the child welfare experts with whom we spoke during our field work. Also important is the caseworkers' care in obtaining information needed to properly assess risk. The State of Washington, which has done an extensive amount of research in the area of risk assessment, found that even in "model" sites, critical pieces of information often were not collected by caseworkers.[138] Clearly, if improvements in assessing the risk of child maltreatment are to result from the use of an empirically-based assessment instrument, implementation must be carefully planned and monitored.

An equally important consideration is that risk assessment instruments are effective only if they employ factors that can be measured easily and accurately by child welfare investigators and caseworkers. The risk assessment instrument developed by NCCD for the State of Michigan has 12 factors for predicting risk of recurrence of abuse and 11 factors for predicting risk of recurrence of neglect. In general, these factors are easily determined by caseworkers. However, some of the factors (caretaker's being abused as a child, caretaker's substance abuse problem, caretaker's domineering parenting style, caretaker's use of excessive discipline, caretaker's lack of parenting skills or self esteem, and caretaker's being a victim of domestic violence) present some degree of difficulty in determining accurately.[139] Documentation of risk factors, currently a problem encountered by children services agencies, will continue to be an issue even if empirically-based instruments are used. Unless children services agencies address shortcomings in these areas, adoption of an empirically-based risk assessment instrument is unlikely to have a significant impact on the agencies' ability to predict future child maltreatment.

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[137] Cicchinelli, L., "Risk Assessment: Expectations and Realities," The APSAC Advisor, 8(4), 1995, p. 5; Cicchinelli, L., and Keller, R., A Comparative Analysis of Risk Assessment Models and Systems, Washington, D.C., National Center on Child Abuse and Neglect, 1990, p. 60; English, et al., op. cit., p. 4-20; English, D., Jewell Morgan, L., and Hoskins, M., Implementation Evaluation: Navy Risk Assessment Model, unpublished report, October 18, 1996, p.11; and Sheets, D., "Implications of Research for the Design and Implementation of Texas Risk Assessment Model," Summary of Highlights from the Fifth National Roundtable on CPS Risk Assessment, Washington, D.C.: American Public Welfare Association, 1991.

[138] English, et al., op. cit., p. 9-3. Among the data most often not collected by caseworkers were substance abuse history and the caretaker's history of abuse as a child.

[139] We should note that these factors generally are included in most risk assessment instruments and are not specific to Michigan's.

Another important consideration is that risk assessment needs to be done throughout a family's involvement with the children services agency and not just during the initial investigation of a report of maltreatment. A single risk assessment vehicle usually is insufficient for measuring risk at all stages of the family's involvement. A different instrument is needed, for example, when the agency must determine whether to return a child home than when it determines whether to remove the child. For the most part, the factors included in the two instruments will be identical, but some will differ. For example, when the agency considers whether to remove the child, the caretaker's receptivity to services offered by the agency may be important, whereas when the agency decides whether to return the child home, the caretaker's progress in the areas that required services will be important.

Finally, as noted above, even when empirically-based risk assessment instruments are used, caseworker judgment continues to play an important role in risk assessment. Unless caseworkers and their supervisors are well trained, adoption of empirically-based risk assessment instruments are unlikely to have a noticeable effect on child safety or resource allocation.

RISK ASSESSMENT IN CALIFORNIA

In early 1996, the Department of Social Services and its consultant held meetings with county child protective services managers, supervisors and case workers to discuss the state of the art on risk assessment and the need for changes in the State's approach to risk assessment. A total of 32 counties were surveyed about their use of risk assessment instruments. Of those counties, 11 indicated they use no formal risk assessment instrument, 18 stated that they use a variation of the risk assessment instrument developed by California State University, Fresno, and three (Los Angeles, Orange, and Merced) use other instruments.[140] Despite their use of the "Fresno model," several counties expressed concern that the Fresno model had not been validated, i.e., it was not empirically-based. From the county children services agencies' other comments, it appears there is some receptivity to using an empirically-based model, or at least in using factors that have been shown to be statistically significant in predicting recurrence of abuse and neglect. However, the agencies seemed reluctant to adopt a uniform, statewide risk assessment instrument and appeared to favor the State's conducting research to validate various risk factors and allowing counties to decide which, if any, of those factors to use in assessing risk.

In light of these county preferences and because of the research pointing to the difficulty of implementing new risk assessment models, we have some concerns about the department's Budget Change Proposal (BCP) for the 1997-98 Governor's Budget to spend $1 million to develop a statewide risk assessment instrument. Unless county children services agencies are

[140] The instrument developed by CSU Fresno was commissioned by the Department of Social Services in the late 1980's and has been used since 1990. The department has promoted the use of the CSU Fresno instrument by offering State-funded training in the use of the instrument to all county child protective services employees.

willing to adopt the new instrument and to closely monitor its implementation, we see little chance of its being effectively implemented, even if legislation is enacted requiring its use. As is often noted in child welfare research, and as we heard from many county child welfare staff and other child welfare experts, if caseworkers do not accept an instrument and if their supervisors do not carefully monitor its use, the caseworkers are likely to continue making the decisions they have always made and to complete the instrument in a manner that is consistent with their already-made decision. According to NCCD, "improved assessments by themselves have limited impact on case practice unless there are clear expectations regarding service delivery and monitoring."[141]

Unfortunately, the BCP that requests funds for development of the risk assessment instrument does not address implementation. We believe that before the department spends funds to develop the proposed risk assessment instrument, the expectations of the Administration, the Legislature and county children services agencies should be clearly set forth regarding implementation, and that the Administration and the Legislature should obtain commitments from county children services agencies to faithfully implement the new instrument once it is developed.

Despite these concerns, we believe that the adoption of an empirically-based risk assessment tool by county children service agencies throughout the State has the potential for increasing the safety of children and for reducing the resources those agencies now devote to low-risk families, thereby increasing the resources they can devote to families at high risk of child maltreatment. Therefore, *we recommend that once the expectations and commitments noted above are set forth and obtained, the department continue its efforts to develop a validated risk assessment model and work with county children services agencies and caseworkers to ensure that the model will be properly implemented after it is developed. We also recommend that the department continue with its plans to train caseworkers in the use of the model but also work with the State's public and private universities to incorporate risk assessment into college curricula for social workers.*

TRAINING

Our literature review of child welfare programs pointed out the value and the necessity of well-trained child welfare services staff to the effectiveness of child welfare programs. This issue was reinforced when we visited county welfare agencies and many officials commented on the importance of staff training while recognizing that their staff would also benefit from more training on child welfare issues. Among the comments that we heard or read were the need for staff to improve their ability to properly determine whether children are at-risk of further abuse and neglect if they remain in their home with their family. Without minimizing the role of county policy or the juvenile court system in deciding whether to remove a child

[141] Baird, et al., op. cit., p. 1.

from home and place him or her in out-of-home care, some experts believe staff are not adequately trained to recognize the strengths of the family or the community and, instead, remove the child from home. Some officials also believe staff are not properly trained in cultural differences and too often rely on personal bias when removing a child because of apparent neglect by the parent or caretaker. In addition, we heard that some staff make poor decisions about what services should be provided to children and their families. In some cases, high-risk families receive few services whereas, in other cases, low-risk families receive more services than are necessary. At a time when resources are limited, decisions about what services are provided to whom become very critical.

We recognize that children services staff are not solely to blame for, or necessarily play a major role in, ineffective program operations. Also, we understand that caseloads for many staff impose tremendous burdens on their ability to make good choices and to provide effective services to their clients. Nevertheless, we agree with the experts on the importance of highly qualified and trained staff. Unless staff are well-trained, there is an increased potential for recurrence of child maltreatment among children with whom they come in contact through emergency reports, and there is increased potential for more children being placed in out-of-home care than is warranted by risk factors alone.

We also acknowledge the current training and staff development efforts of the Department of Social Services and the counties to ensure that personnel at all levels are provided comprehensive training. California county-initiated training and staff development is expected to cost $11 million during the current federal fiscal year with more than 60,000 county staff attending a variety of workshops.[142] Some counties are placing a high priority on training and staff development. For example, Los Angeles County has developed an alliance with the graduate departments of social work at California State University, Long Beach and the University of California, Los Angeles to improve services for at-risk children and their families by strengthening the skills of county employees.

In addition, the department is sponsoring several training and staff development efforts. In particular, due to the shortage of professionals holding a Master of Social Work (MSW) degree, using Title IV-E funds, the department has an agreement with the California Social Work Education Center (CalSWEC) at the University of California, Berkeley to administer a MSW stipend program. Under the program, participating students receive up to $15,000 a year to attend one of eleven schools of social work to earn an MSW degree. In return, the student commits to employment in a California county child welfare services organization for a prescribed period of time. The department also is working with county welfare departments to establish at least five regional training academies. These training academies are intended to provide uniform, competency-based training that is based on the CalSWEC competency-based model for MSW education.

[142] The number of county staff attending workshops is not an unduplicated count as many staff attend more than one workshop during a year.

We note that the State has not established any minimum competency-based standards for child welfare social workers. Instead, the State mandates that 50 percent of the caseworkers and 100 percent of the supervisors in the Emergency Response and Family Maintenance Programs hold a MSW degree. However, we were informed by department staff that current regulations allow counties to avoid the requirement. In addition, the department and the CWDA have developed proposed goals for social worker training but such goals have not been formally adopted to date.

Some child welfare advocates suggest that the State should establish a certification program with minimum competency-based standards for child welfare social workers. They argue that such a program is necessary to bring a degree of professionalism to child welfare services and ensure that all social workers have an understanding of the critical skills essential to carry out the mission of the social services agency. Because social workers have the legal authority to remove children from their homes without any further immediate legal action, the advocates believe the workers should be well-trained to effectively handle these situations.

JUVENILE JUSTICE PROCESS

During our visits to county welfare agencies, county officials spoke of different practices of the juvenile court system that alter the directions of child welfare services. In addition, other issues surfaced from discussions with judges and other officials of the juvenile court process and from our attendance at the "Beyond the Bench VIII Conference" in San Francisco in December 1996. Even though we have not conducted extensive review of these matters, we present some issues for possible further consideration by State policy makers.

The first issue pertains to the judicial, as well as community philosophy, towards child safety and child rights as contrasted with family/parental rights. While we found little disagreement that child safety is the premier concern of the child welfare system, we learned that the philosophy of the court and the local legal community does influence the children services agency's decision to remove children from their homes. We heard that because of the court and/or community pressures to minimize the risk of harm to children, staff in some counties are removing children from their homes when other counties might be inclined to provided family preservation services while the child remains at home. In some cases, children services agencies may be taking no chances: their actions may be designed to minimize the risk of harm to children, or the adverse publicity that occurs when a child is harmed after he/she is left at home following a substantiated or suspected case of child maltreatment. These risk-averse actions may well be responsible for a significant percentage of the children in foster care today. We hasten to add that neither we nor the county officials with whom we spoke are advocating that children remain in their homes when their homes are unsafe. Nevertheless, the practice of "when in doubt, pull them out" is contrary to federal law which requires that "reasonable efforts" be made by county children services agencies to provide

services to the family so that the child can remain safely at home. It is also contrary to the recommendations of many child welfare advocates who believe that children are emotionally harmed when they are removed from their families.

On the other hand, some county officials stated that effective and efficient child welfare services are compromised by the judicial process if the court and/or the community are advocates of parental rights. Under these circumstances, extensive legal proceedings involving attorneys and advocates for children and families can delay timely services to families in need. This situation is compounded if the family and the court have an adversarial relationship. Furthermore, as the number of attorneys and advocates become increasingly involved in an individual case, scheduling court-required hearings becomes very difficult. We heard complaints from several county staff regarding such delays. However, one judge with whom we spoke stated that more significant delays occur because of children services agencies' organizational structures. According to him, there are frequent delays of two or more months in providing services to families who have had children placed in out-of-home care because of the "hand-off" of the case from the staff who present the agency's findings before the court to the staff who manage the case after the court has approved the out-of-home placement.

We also heard that courts sometimes order services for a child or family that are not readily available within the county. Because family reunification efforts are often dependent on the provision of court-ordered services, reunification may be delayed until the services become available. We were told this situation is problematic in many rural counties which have limited services, such as substance abuse treatment programs. In many instances, these treatment programs have waiting lists and a parent may wait several months before entering the program.

Several practitioners within the child welfare system believe the courts and county children services agencies are not adhering to the time frames established in federal and State law.[143] As we noted in Chapter 1, current law requires certain actions to occur within specified time limits, e.g., under normal circumstances, the court is required to approve a permanent placement plan for a child in out-of-home care within 18 months of the child's removal from home. According to one practitioner, many courts and children services agencies view these time frames as guidelines rather than mandated limits. The result of this practice is that children continue to "drift" in the foster care system.

We have no way of knowing the extent of these procedural delays. However, regardless of their causes, if procedural delays are occurring, children admitted to foster care for

[143] Under a contract with the Department of Social Services, the Judicial Council of California is reviewing local juvenile court procedures, processes and documentation to determine compliance with federal law, and providing technical assistance to the court when deficiencies are noted.

temporary protection are being delayed in returning home to their families, adding to an already high foster care census.

Many child welfare advocates say the initial removal from home is the most detrimental experience for children, in some cases worse than the actual incident of abuse or neglect. Some children are removed from home by law enforcement officials who respond to a reported illegal activity if, in the opinion of the law enforcement official, the children cannot remain safely at home. Frequently, the children are placed in an emergency shelter until the county children services agency is contacted and the children can be placed in a more appropriate placement. We were told that this harmful, emotional experience for children may be avoided, or at least minimized, in some situations if law enforcement first consults with the county children services agency. While removal from the home may not be avoidable, a trained social worker may be better able to assess risk of recurrence of the maltreatment and is better able to locate more desirable out-of-home care, possibly at the home of a relative.

DATA COLLECTION, REPORTING DIFFERENCES & DEFINITIONS

Many program administrators and researchers recognize the importance of collecting both current and historical program data describing the client population and the services provided to the clients. To an administrator, data are useful to understand the characteristics of the population so that services can be tailored to meet the population's needs. As changes occur in population characteristics, the administrator can alter the services or the service delivery system. To a researcher, historical data often establish the benchmark conditions from which changes can be measured, using current data, to determine whether a program is accomplishing its intended outcomes. Without current data, the researcher has difficulty concluding whether the client population is better off, unaffected, or even worse off, after receiving program services.

Despite this, we found that few data are currently available on a nationwide or statewide basis to enable evaluators to make definitive judgments about the effectiveness of child welfare programs. Rather, most of the available data are limited to describing numbers and characteristics of children in foster care, information about the reports and disposition of allegations of child abuse and neglect, or an occasional report on nationwide adoptions. Moreover, even these data have limited application because most are submitted to national organizations on a voluntary basis, and differing policies and procedures among reporting jurisdictions often make the data non-comparable. In Chapter 3, we described the data that are available along with the data sources and we compared California's child welfare system with other selected states. However, as we noted in Chapter 3, the limitations of the data make comparisons with other states of limited value.

We also learned of program differences among California counties which make valid comparisons among the counties very difficult. A county's policy regarding kinship placements, for example, may impact data on average length of stay in out-of-home placement while also affecting the number of adoptions within the county. Also, we noted that, despite the existence of a uniform statewide emergency protocol, counties have different policies regarding criteria for determining which reports of abuse and neglect are investigated by child welfare workers.

While we are not suggesting that comparisons among states or among California counties should not be performed (in fact, they can serve useful purposes), extreme caution should be exercised when making conclusions based on the data. Moreover, when making such comparisons, researchers should take precautions to ensure the data, in fact, are comparable or provide explanations of possible policy or differences in definitions among the reporting entities that might contribute to inconsistencies in the data.

In addition, we found differences among programs that have similar titles. For example, as we noted in our discussion on home visiting programs, existing programs contain tremendous variations concerning when services are initiated, the types of services and the duration of the services. Further, by design, family preservation and support services programs are established at the local level to meet local needs. As a consequence, the focus, type and intensity of services create differences from one program to another. Therefore, judgments or research concerning the effectiveness of one program may not apply to a similarly named program.

Despite the shortcomings of the current data systems, most child welfare staff with whom we spoke are optimistic about the future. As we reported in Chapter 3, through the newly created federal Adoption and Foster Care Analysis and Reporting System (AFCARS), nationwide data will soon be available to program administrators and researchers. Because of California's participation in the federal effort, the State's Child Welfare Services/Case Management System (CWS/CMS) affords State and local officials the opportunity to measure the effectiveness of child welfare services. Lacking, however, is an effort by State and local decision-makers to establish meaningful outcomes for the program and efforts by child welfare practitioners to collect data with which to measure the effectiveness of their activities and programs.

ADMINISTRATIVE ISSUES

When asked to comment on barriers to effective child welfare services during our visits to county children services agencies, some officials identified the lack of coordination and collaboration among county agencies that provide services to children and families. They noted that many children and families have multiple needs, including health, mental health and educational, as well as child welfare needs. In addition, some children and families have

little or no contact with the county probation agency. The officials noted that, at times, the lack of common objectives for a child or family results in competing services which may be duplicative or conflicting, not to mention inefficient. They noted that some counties, such as Placer County, have reorganized their county agencies to bring together service organizations that provide services to families and children under one administrator. They also noted that several counties, through the Department of Mental Health's Children's System of Care Program, established collaborative efforts among county agencies but those efforts target a select group of children and such efforts have not been expanded to other service areas.

One county official suggested that the State consider allowing counties to contract with private agencies to perform certain child welfare tasks. The official noted that court-ordered, supervised visits between children and their parent(s) probably could be performed more efficiently through community-based providers. He also noted that these same community based providers probably could perform many routine home visits because of their close contact with the families. Also, contracting with retirees to perform monthly visits when out-of-county travel is involved may be more efficient than sending county staff.

Another county official recommended that the State reduce the workload of the juvenile courts by enhancing county efforts to establish an "administrative body," as allowable under federal law, to perform certain mandated reviews.[144] In particular, the official noted the large number of court dependent children are living with relative caretakers under long-term foster care agreements. In the situation where a stable relationship has been established between the child and relative, the official believes an administrative body could conduct required review thereby easing the court's workload.

When speaking to one of California's juvenile court justices, he spoke of the "hand-off" concept that sometimes occurs within a county children services agency. As he described the process, a county intake worker has responsibility for a case until a case plan is approved by the juvenile court. This responsibility could include identify types of services necessary to protect the child and/or maintain or reunify the family. After the case plan is approved, the case is "handed off" to a caseworker. Occasionally, because of workload or other matters, the new caseworker may not check on the family until the next regularly scheduled monthly visit. In the meantime, if a parent has been directed to attend parenting training, counseling or a substances abuse treatment program, the parent may not know where or how to obtain the services and receipt of the services may be delay for weeks, if not months.[145] Moreover, this delay can be extended if the parent is placed on a waiting list by a service provider. As a result of this situation, the child's reunification with the family is generally delayed.

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[144] Current federal and State law require that the court or an "administrative body" conduct a thorough review of case progress at least once every six months to ensure that cases are not neglected and, if necessary, to refine the case plan. While administrative bodies are permissible under current State law and regulation, reportedly they duplicate rather than replace court reviews as juvenile courts want to sanction any changes to case plans.

[145] The judge also noted that some intake/caseworkers merely hand parents a list of service providers without assisting in arrangements for the services, including appointments, transportation and child care, if necessary.

Outside Influences

The effectiveness of child welfare programs depends on two types of factors or influences: those controllable by the child welfare program and those over which the program has minimal or no control. We found that external factors can and do influence expected outcomes of child welfare programs. For example, as we have discussed elsewhere in this report, abused and neglected children frequently have multiple health and social needs. In response, public agencies have established several service delivery systems which, all too often, fail to coordinate their efforts. As a result, these children and their families may be receiving services from more than one public agency even though the services are intended to impact the same need. Consequently, when evaluators attempt to measure the success or effectiveness of any one program, they find that other programs have influenced the child's or family's current conditions. Unless precautions have been taken to identify and control for these other program impacts, evaluators cannot measure the effectiveness of the child welfare program.

Other extrinsic influences, such as a change in the economy, can impact the effectiveness of child welfare programs. When a program targets services to a community that experiences an economic downturn, the number of reported incidents of child abuse and neglect may increase. However, if the only measure of program effectiveness is a reduction in reports of abuse and neglect, the program may be deemed ineffective.

We found that few, if any, child welfare programs have designed their evaluations to identify and control for outside influences. In the absences of this action, evaluators cannot state, with a high degree of confidence, that the programs are effective or ineffective in accomplishing intended outcomes.

Conclusions

Although several issues discussed in this chapter are beyond the scope of our study, we believe that some of them may have merit. Inefficient procedures among children services agencies have major implications for child safety and for the number of children retained unnecessarily in foster care. Because of this, we believe these issues should be pursued by the Department of Social Services, perhaps through pilot projects or through forums similar to those being held today for foster care or kinship care.

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CHAPTER 8
FUNDING THE CHILD WELFARE SYSTEM

INTRODUCTION

The primary responsibility for administering child welfare services programs rests with the states. The role of the federal government in the child welfare services arena is principally confined to establishing overall programmatic requirements and goals, providing funding and ensuring that states comply with federal requirements. States are responsible for actually administering the programs. In California, the State monitors and oversees the operational program aspects of the child welfare programs through the development of policy, regulations and procedures for the delivery of services, and the monitoring and evaluation of services delivered. Additionally, the State pilots innovative programs and service delivery modes. The State also provides funding to the counties for programs and to match federal funding requirements.

Although programs are authorized and established primarily at the federal and state level, the child welfare system is a county-driven system. Counties are principally responsible for the day-to-day administration of programs and providing services to clients either directly or through contracts with private non-profit agencies. Typically, clients of the child welfare system will have most of their dealings with the county level of government. Some clients may interact with state hospitals or with state adoption agencies, but for the most part counties have the only contact with clients of the system. Counties are also responsible for funding a share of the costs of most programs. However, there are some programs in which counties have no share of costs.

Child welfare programs comprise a continuum of services, treatments and interventions intended to keep children safe from abuse or neglect. Programs vary both in terms of how directly they intervene in the lives of children and families and in how much discretion individuals have in participating in the programs and services offered. Child welfare programs generally can be divided into two broad categories: 1) programs that provide services or treatment, and; 2) programs that provide for alternative living arrangements for children who cannot be safely maintained in their own homes. For example, parenting classes that are provided under the Family Maintenance Program would fall under the first category of programs. Placement of a child with a foster family through the Foster Care Program

would fall under the second category of programs. Each of these two broad categories encompasses a wide array of programs, services and placement options.

Services and treatment programs tend to focus on making a child's home environment safe in order to keep an at-risk child and the child's family intact. If the child is already out of the home, the services and treatments offered would likely focus on addressing the problems that resulted in the child's removal so that the child and family can be reunited in a home environment that is free from abuse or neglect. Placement programs focus on keeping a child safe from abuse or neglect by removing the child from a home which has been determined to be unsafe for the child or in which the risk to the child is too great. The alternative living arrangements provided through such programs most often are temporary, pending resolution of the issues which caused removal of the child. However, such alternative living arrangements can be long-term or even permanent.

This chapter provides an overview of the funding structures for various child welfare programs. Our review details the various funding sources currently in place for programs and the methodologies for developing program allocations and budgets. Our review focuses primarily on federally-established and statewide programs. However, selected county-operated programs and state pilot programs are also included. Table 8-1 categorizes the major child welfare programs for fiscal year 1996-97 by funding source.

PROGRAM FUNDING SOURCES

Child welfare programs in California have three principal funding sources: the State General Fund, federal funds and county funds. In addition, some programs are funded from State and local special funds. General Fund monies are allocated to counties through the Department of Social Services, based upon program caseloads and according to statutory funding formulas and cost sharing ratios. The department also allocates federal funds to the counties in accordance with federal requirements.

Federal Funding Sources

The Social Security Act is the primary source of federal funds for child welfare programs. The Social Security Act includes both non-entitlement (funding levels are determined through the annual appropriations process) and entitlement authorizations (funding is open-ended for the costs of serving any individual that meets the eligibility criteria established in law). The federal funding sources include the following: Title IV-A, Title IV-B, Title IV-E, Title XIX, Title XX, and Child Abuse Prevention Grants.

TABLE 8-1
CHILD WELFARE PROGRAMS
FUNDING SOURCES AND PROGRAM BUDGETS FOR 1996-97
(Dollars in Millions)

Program	Type	Funding Sources	Status	Budget
Adoption Assistance Payments	Intervention	General Fund / Federal IV-E Funds / County Funds	Statewide	$ 131.0
Adoptions	Intervention	General Fund / Federal IV-E Funds	Statewide	$ 54.5
Child Abuse Prevention	Prevention	General Fund / State Children's Trust Fund / Federal Grants	Statewide	$ 13.9
Child Welfare Services	Both	General Fund / Federal IV-A, IV-B, IV-E, XIX / County Funds	Statewide	$ 925.3
Federal Family Preservation & Support	Both	Federal IV-B	Statewide	$ 23.0
Foster Care	Intervention	General Fund / Federal IV-A & IV-E / County Funds	Statewide	$ 1,653.2
Home Visitation Programs	Prevention	General Fund	Pilot	$ 10.0
Independent Living Program	Intervention	Federal IV-A	Statewide	$ 11.5
Juvenile Crime Initiative Programs	Prevention	General Fund	Pilot	$ 10.0
Options For Recovery	Intervention	General Fund / Federal IV-E / County Funds	Pilot	$ 6.4
State Family Preservation	Both	General Fund / Federal IV-E / County Funds	Both	$ 45.1
Wrap Around Services (AB 2297)	Intervention	General Fund / Federal IV-E / County Funds	Pilot	$ 7.1
Youth Pilot Project (AB 1741)	Intervention	General Fund / Federal IV-E / County Funds	Pilot	Unknown
			TOTAL	**$ 2,891.0**

Title IV-A

Until October 1, 1996, Title IV-A provided a federal entitlement that included the Aid to Families with Dependent Children (AFDC) program, commonly referred to as "welfare" and, the Emergency Assistance (EA) Program. Federal welfare reform legislation eliminated this title as of October 1, 1996 and replaced it with the Temporary Assistance to Needy Families (TANF) block grant. The Title IV-A components are discussed below.

AFDC - Prior to the welfare reform legislation, the AFDC program provided financial assistance in the form of cash grants or food stamps to eligible individuals who were unable to support themselves. Because the program will undergo significant redesign under welfare reform and because AFDC is not generally considered a part of the child welfare system, our review does not focus on AFDC as a child welfare program. However, some children in out-of-home kinship placements received AFDC grants. When the AFDC entitlement was in place, federal Title IV-A funded 50 percent of the costs and the remaining costs were split between the state (95 percent) and the counties (5 percent).

Emergency Assistance (EA) - Under Title IV-A, the EA program essentially provided an alternative federal funding source for child welfare activities that would normally have been part of other child welfare programs but may not have qualified for federal funding under the federal titles that fund those programs. EA provided funding for foster care for wards of the juvenile court, for otherwise non-federally eligible foster care placement for dependents of the court or voluntary placements, county juvenile assessment and residential treatment facilities, services to families in crisis to prevent removal of children from their homes, emergency shelter costs, and case management.

Under EA, federal Title IV-A funded 50 percent of eligible costs. The non-federal share of costs were split between the State and counties according to the normal cost sharing ratios in the programs which would otherwise have funded the specific activities. Use of EA funding was restricted to activities and services for children and families in emergency situations. Additionally, eligibility was restricted to once in a 12-month period. Under the TANF block grant, states have the option of using TANF funds to continue funding costs that were previously funded through EA.

Title IV-B

Title IV-B has two components:

Part I - This component permanently authorizes 75 percent federal matching grants for services that protect the welfare of children; address problems that may result in neglect, abuse, exploitation or delinquency of children; prevent the unnecessary separation of children from their families; and, when appropriate, restore children to their families. This is the

primary federal funding source for services provided through the CWS program. There are no income eligibility requirements for the receipt of child welfare services. Part I is a capped entitlement authorization in the amount of $294.6 million annually. California's Part I allocation in 1996-97 is approximately $31.1 million.

Part II - This is a capped entitlement that was established in federal fiscal year 1994 to provide grants to states for family preservation and family support services. The funding was authorized for 5 years at the levels reflected in Table 8-2.

TABLE 8-2
FEDERAL TITLE IV-B PART II ALLOCATION BY FEDERAL FISCAL YEAR
FAMILY PRESERVATION AND FAMILY SUPPORT PROGRAM
(Dollars in Millions)

	1994	1995	1996	1997	1998
National Total	$60.0	$150.0	$225.0	$240.0	$255.0
California	$6.9	$16.6	$26.0	$27.9	$29.7

Source: 1994 Federal Green Book: Overview of Entitlement Programs

Title IV-E

Title IV-E provides federal matching funds for out-of-home placement costs (e.g., Foster Care and Adoptions Assistance Payments programs), program administrative costs and costs that are not for direct services to children or their families. Title IV-E, federal funds are only provided for costs associated with cases where the child would have been eligible for AFDC or SSI if the child were still in the home. However, there are two exceptions to the AFDC-eligibility requirement. Title IV-E matching funds may be claimed for the non-recurring costs associated with the adoption of children with special needs and the costs of Independent Living Program services which facilitate the transition of children from foster care to independent living. These costs are eligible for Title IV-E matching funds regardless of whether the children served are eligible for AFDC or SSI.

Title XIX

Title XIX provides federal funding for health care services provided through the Medi-Cal program to low income and indigent individuals. Title XIX funding is available at the State's Medicaid rate (California's rate for 1996-97 is 50.23 percent and will increase to 51.23 percent for 1997-98) for the costs of providing medical treatment to children that come into the child welfare system. Title XIX funding is available for costs associated with children that are eligible for Medi-Cal due to their eligibility for AFDC or SSI.

California's Title XIX allocation for CWS totals $17.1 million in 1996-97 and is reflected in the budget for the CWS program.

Title XX

Title XX provides a capped $2.8 billion entitlement program. Title XX funding is block-granted to states on the basis of population for a wide range of social services programs. States have discretion over how Title XX funds are allocated among programs that serve children, adults or individuals with disabilities. States are also given wide discretion to determine the services to be provided and the eligibility criteria for receipt of services. In addition to supporting social services, Title XX funding may be used for staff training, administration, planning, evaluation, and contracts for technical assistance in developing, implementing, or administering social services programs. There are no AFDC or SSI eligibility requirements. However, the following restrictions apply to the use of Title XX funds. With some exceptions, funds cannot be used for the following: medical care; rehabilitation and detoxification services; purchase of land, construction or major capital improvements; room and board except emergency short-term care; educational services provided by public schools; social services provided in and by hospitals, nursing homes or prisons; subsistence payments; daycare services provided in unlicensed facilities; and wages to individuals as a social service.

California's 1996-97 allocation of Title XX funds is approximately $236.1 million. However, California does not use Title XX funding for child welfare services programs. Instead, California utilizes Title XX funding to provide in-home supportive services for adults, developmental services and employment training for individuals with developmental disabilities, and to license child care programs. Nevertheless, Title XX is listed here as it is available as a funding source for child welfare programs.

Federal Child Abuse Prevention Grants

California receives various federal child abuse prevention and treatment grants each year. The grants fund programs and services through state, local and private agencies that are designed to prevent child abuse or neglect. Specific examples of such programs include: respite care for parents of at-risk children, community-based family resource referral services, and child abuse education and public awareness campaigns. In 1996-97, California received a total of $3.4 million in federal grants.

FUNDING FOR SPECIFIC PROGRAMS

Adoptions

The Adoptions program provides for the placement of children with adoptive families in cases where parental rights have been voluntarily relinquished or where the court has terminated parental rights due to abuse or neglect. The program also provides placement services in cases where parents place a child directly with an adoptive family of their choice. All adoptions through the program are made either through the State or through a licensed adoption agency. As indicated in Chapter 1, thirty-one counties either operate their own adoptions programs or contract with other counties for adoption services. The State provides adoption services in the rest of the counties which are primarily smaller and which do not have large enough adoptions caseloads to make operating their own programs fiscally viable.

Adoptions program costs are funded by the State and federal governments. Counties do not have a required share of costs. The State share of costs are funded from the General Fund. Federal Title IV-E funding is available at the rate of 50 percent for costs associated with the adoption of children that are AFDC- or SSI-eligible. The 1996-97 budget for the Adoptions program operated by the State totals $11.8 million ($8.1 million General Fund / $3.6 million federal funds). This amount also includes funding for the State's policy and oversight functions for the Adoptions program. The 1996-97 budget for county-operated adoptions programs totals $42.7 million ($28.2 million General Fund / $14.5 million federal funds).

Prior to 1996-97, funding for the counties' administrative costs of operating the program had been based upon workload standards established in 1980. Over the sixteen years since the workload standards had been developed, many changes in the adoptions process and in the make up of the adoptions caseload had occurred which made adoptions more complex and time-consuming. Accordingly, the workload standards used to fund county Adoptions programs resulted in counties being under-funded for projected caseloads. This was a significant concern as the majority of the children placed for adoption through public agencies come from foster care.[146] Out of concern over growing foster care caseloads and the length of time children remained in foster care, the State implemented the Governor's Adoptions Initiative in 1996-97. The Adoptions Initiative provided approximately $27.2 million ($17.0 million General Funds / $10.2 million federal funds) annually in additional funding for county Adoptions Programs.

[146] California Department of Social Services, Adoptions In California, Quarterly Statistical Report, June 1993, indicates that of 1,198 completed public agency adoptions, 902 were adoptions of children previously in foster care.

Adoptions Assistance Payments (AAP)

The Adoptions Assistance Payments (AAP) Program provides financial support to families adopting a child that has special needs. Children are deemed to have special needs if they have any of the following characteristics: mental, physical, medical or emotional handicap; ethnic or minority background or race; non-English speaking; more than three years of age, member of a sibling group to be adopted by one family; adverse parental background (e.g., parents with drug addiction, mental illness or other conditions). Families adopting special needs children are provided a monthly grant until the child reaches age 18 (age 21 for children with mental or physical handicaps). AAP eligibility is reviewed every two years.

The amount of AAP grants is based on the circumstances of the adopting parents and the needs of the child. However, there is no means test for the parents to be eligible for the program. Payments may not exceed the amount the family might have received on behalf of the child under foster care, and payments are discontinued if the parents are no longer legally responsible for the support of the child.

The AAP program is an open-ended entitlement program required under federal law. Federal Title IV-E matching funds are provided for AAP grants to parents who adopt AFDC- or SSI-eligible children. The federal matching rate for the adoption assistance payments is based on each State's Medicaid matching rate (California's rate is 50.23 percent in 1996-97 and will increase to 51.23 percent in 1997-98). In addition, Title IV-E authorizes federal matching funds at the rate of 50 percent for the costs of administering the program and at the rate of 75 percent for training both staff and adoptive parents. Further, Title IV-E also authorizes federal matching funds at the rate of 50 percent for one-time adoption expenses associated with adoption of special needs children (regardless of the child's AFDC or SSI eligibility). Parents may receive reimbursement of up to $2,000 per child for qualified adoption expenses such as adoption fees, court costs, attorney fees, and other expenses that are directly related to the adoption of a child with special needs. California law, however, limits the reimbursement for these one-time expenses to $400.

The 1996-97 budget for AAP totals $131.0 million ($65.7 million General Fund / $43.8 million federal funds / $21.6 million county funds).

We note that unlike other child welfare programs, there are few pilot projects or innovative models for adoptions services. In recognition that county adoptions rates vary dramatically, the Adoptions Initiative includes resources for the State to review the practices of counties with high adoptions rates, and promote those county activities that produce better results.

Child Abuse Prevention Programs

The State funds and monitors programs and services through state, local and private agencies that are designed to prevent child abuse or neglect. Agencies are awarded time-limited funding through the State for implementation of local and community-based programs. Funding from the State Office of Child Abuse Prevention (OCAP) is intended to allow agencies to pilot new prevention programs or innovative service delivery modes. Agencies are encouraged to seek alternative funding sources to continue programs after OCAP funding expires. The 1996-97 budget for child abuse prevention programs totals $23.6 million. As counties do not have a share of costs, funding comes entirely from federal grants ($3.4 million) and from the State ($19.5 million General Fund and approximately $0.7 million Children's Trust Fund). These totals include funding for the Juvenile Crime Initiative programs discussed later in this chapter.

Child Welfare Services

Child Welfare Services (CWS) is the program umbrella which encompasses most of the programs that provide services for abused children and their families to maintain or return the children to their homes. There are four principal program components in the CWS program:

- Emergency Response - Provides initial assessments and in-person response to reports of suspected child abuse and intake services. County personnel (most often Child Protective Services staff) determine whether an in-person investigation is required to substantiate or disprove the allegation of child maltreatment, conduct the investigation when needed and identify which if any services are required to prevent further maltreatment from occurring. Typically, an emergency response case, once opened, must be resolved or referred to one of the other programs within 30 days.

- Family Maintenance - Provides time-limited protective services while the child is in the home to prevent or remedy neglect or abuse and to prevent the separation of children from their families. County staff determine the specific service needs of the child and family in order to maintain the child in the home. Services are either purchased from community agencies or provided directly by county social workers.

- Family Reunification - Time-limited services to prevent or remedy neglect or abuse which are provided while the child is in temporary out-of-home placement or when the child cannot safely remain at home. County staff determine the specific service needs of the child and family in order to reunify the child and the family. Services are either purchased from community agencies or provided directly by county social workers.

- Permanent Placement - When a child cannot safely remain at home and a court has made the determination that the child is unlikely to ever be reunified with the family, county

staff, together with the courts, determine and facilitate an alternative permanent living arrangement for the child. The goal of such placements is to provide the child with the least restrictive and most home-like environment that is appropriate to the needs of the child and that will provide a safe and nurturing environment. The options include kinship care, legal guardianship, adoption, or long-term foster care.

Funding for the CWS program is from a combination of various federal funding sources, State General Fund and county funds. Title IV-B provides a capped allocation of $31.0 million in federal funds for the services component of CWS. These funds provide a 75 percent match, with the non-federal share of costs split between the State (70 percent) and counties (30 percent).

County allocations for the CWS program are derived by developing estimates of caseloads for each county for each individual CWS component (Emergency Response, Family Maintenance, Family Reunification, Permanent Placement). The caseload estimates use actual caseload statistics for the previous three years. Additionally, individual counties provide additional information to explain any extraordinary fluctuations in caseloads. Standard workload ratios are then applied to the corresponding caseloads in each program component to determine the number of social workers that each county will need. The workload standards were developed in 1984. The ratios for each component are as follows:

CWS Component	Number of Cases Per Social Worker
Emergency Response Assessments	300.0
Emergency Response 30-day Cases	15.8
Family Maintenance	35.0
Family Reunification	27.0
Permanent Placement	54.0

After the number of social workers has been determined, a ratio of 1:7 is applied to determine the number of supervisors needed. The number of social workers and supervisors are totaled and multiplied by the annual statewide cost of a social worker ($95,518 in 1996-97) to determine individual county CWS allocations. The annual statewide cost of a social worker is determined annually based on proposed county administrative budgets and includes overhead and support costs.

Family Preservation Program

The State Family Preservation Program (FPP) authorizes counties to utilize State foster care funding to provide intensive short-term services tailored to the needs of families in crisis to prevent the abuse or neglect of children and allow children to remain safely in their homes. These are provided as an alternative to out-of-home foster care placement. The services provided are not limited to the traditional social services provided through family maintenance and family reunification programs (i.e., families can be provided with funding to arrange living accommodations, intensive parenting and household management training, or transportation to medical appointments). The goals of FPP are to ensure the safety of the child, prevent foster care placement, and improve family functioning skills so the family can remain intact.

The FPP is split into two components, the pilot program and the permanent program:

- FPP Pilot - Counties wishing to implement FPP on a pilot basis may request that up to 25 percent of their projected foster care allocation be transferred to their CWS program for implementation of family preservation services. While in the pilot phase, counties are subject to the penalty provisions prescribed in statute if they over-expend their foster care allocations and to the incentive provisions which allow counties to retain savings in foster care generated through the FPP. During the pilot phase, counties do not have a share of costs for FPP. Some of the social work costs associated with FPP are eligible for federal matching funds under Title IV-E. The 1996-97 budget for the pilot component of the FPP totals $30.6 million ($26.6 million General Fund / $4.0 million federal funds).

- FPP Permanent - Once a county has operated FPP for a period of three years it can seek to permanently establish the program and to have foster care funds permanently transferred to its CWS program. The amount of the transfer cannot exceed 70 percent of the highest annual amount expended by that county for FPP. In addition, the county picks up a 30 percent share of all non-federal costs. Once a county transitions from the pilot phase to permanently establishing FPP, the county is no longer subject to the incentive and penalty provisions of the FPP statutes. The 1996-97 budget for the permanent component of FPP totals $14.5 million ($7.3 million General Fund / $4.1 million federal funds / $3.1 million county funds).

Federal Family Preservation and Family Support Program

The Federal Family Preservation and Family Support (FPFS) Program is a capped federal entitlement program in which Title IV-B funding is provided to counties for family preservation programs and programs intended to provide community-based preventive and family support services to prevent child abuse or neglect or to enhance the functionality of families.

Family Support Services: are primarily community-based preventive activities designed to alleviate stress and promote parental competencies and behaviors that will increase the ability of families to successfully nurture their children; enable families to use other resources and opportunities available in the community; and create supportive networks to enhance child-rearing abilities of parents and help compensate for the increased social isolation and vulnerability of families.

Family Preservation Services: are intensive short-term services aimed at avoiding out-of-home placement of children; making children safe from abuse or neglect in their homes; and supporting families preparing to reunify.

The goals of the FPFS program are to:

1. Reduce the number of children in out-of-home care, and reduce the length of time children remain in out-of-home care;
2. Reduce the rate of recidivism in cases of child abuse or neglect in families served through the program;
3. Increase the functionality of families served through the program by reducing or eliminating the behavior or conditions that place children at-risk of abuse or neglect; and
4. Reduce program costs by reducing the number of children in out-of-home care.

Foster Care

This is an entitlement program which provides monthly grants to pay for the board and care costs of children placed in out-of-home care. Foster care providers range from small family homes where a single child may be cared for to larger intensive group homes which may provide structured and intensive treatment and educational services to residents. Additionally, some children that are seriously emotionally disturbed who are beyond the control of their parents are voluntarily placed through the Foster Care program in residential placements that provide specialized schooling in non-public schools. The Foster Care program is administered by the counties in accordance with State and federal regulations and standards. The goal of foster care is to provide children, whose families do not provide suitable care for them, physical care, emotional support, and other services to protect children from abuse and promote their growth and development.

Foster care placements are considered temporary and children in foster care will usually be part of the Family Reunification caseload. Children remain in foster care until a court determines that the child can be reunited with its family in a home that is safe from abuse or neglect. If the child cannot be safely reunited with its family, a number of more long-term or permanent placement options will be pursued. These can range from placing the child in the care of relatives or kin, or with a non-related legal guardian. Additionally, once parental

rights have been terminated a child can be placed for adoption or in a long-term foster care placement.

Foster Care maintenance payments are eligible for federal Title IV-E funding if the child received, or would have been eligible for, AFDC or SSI prior to removal from the home. The following requirements must also be met: (1) the placement was a voluntary placement agreement signed by the child's parents or guardians or based on a judicial determination that remaining in the home would be contrary to the child's welfare; (2) reasonable efforts were made to eliminate the need for removal or to return the child to his home; and (3) care and placement of the child are the responsibility of specified public agencies. Appendix K lists the standard monthly foster care payment rates.

The federal matching rate for child placements and administrative costs is a State's Medicaid matching rate (California's rate is 50.23 percent in 1996-97 and is projected to increase to 51.23 percent in 1997-98). Under federal regulations the following are allowable child placement and administrative costs for the Foster Care Program: the costs of food, shelter, clothing, daily supervision, school supplies, general incidentals, liability insurance for the child, travel to the child's home for visits, referrals to services, preparation for and participation in judicial determinations, placement of the child, development of the case plan, case reviews, case management and supervision, recruitment and licensing of foster homes and institutions, rate setting, and a proportionate share of agency overhead.

States also may claim federal matching funds at a rate of 75 percent to train both personnel administering the program and foster and adoptive parents. Additionally, during federal fiscal years 1994-97, states were authorized to receive federal matching funds at the 75 percent rate for eligible costs related to automated child welfare information systems. Foster children are also eligible for Medi-Cal.

Kinship Care - The placement philosophy in foster care is that children in foster care should be placed in the least restrictive and most home-like setting. It is generally accepted that keeping a child in or near the child's own community will result in less of a disruption of the child's life. Accordingly, children are often placed in with their own relatives or "kin" when appropriate and when such placements are available. This type of placement is commonly referred to as kinship foster care.

The 1996-97 budget for the Foster Care program totals over $1.6 billion ($341 million General Fund / $397 million federal funds / $894 million county funds).

Independent Living Program

In 1986, an annual federal entitlement of $45 million was established for the Independent Living Program to assist AFDC-eligible youth age 16 and over make a successful transition

from foster care to independent adult living when they become ineligible for foster care maintenance payments. The federal allocation was subsequently expanded to $70 million annually and the program expanded to provide independent living services to non-AFDC eligible youth; and to provide follow-up services for up to 6 months after emancipation from foster care. States have the option of serving individuals up to age 21. Independent Living Program funds are allocated on the basis of each state's share of children receiving Title IV-E foster care in 1984. States are required to provide 50 percent matching for any federal funding claimed that exceeds the original $45 million funding level.

The 1996-97 budget for the Independent Living Program totals $11.5 million federal funds.

Juvenile Crime Prevention Initiative

This is a program implemented in the 1993-94 fiscal year intended to reduce the incidence of juvenile crime, prevent the abuse and neglect of children and strengthen families. The program is comprised of early intervention and family support services, parenting skills and educational and supervised recreation activities designed for at risk youth and their families. Twelve pilot Family Resource Centers (FRCs), were established in communities with high rates of juvenile arrests, reported child abuse, out-of-home placements or teen pregnancy. These centers provide the following direct services to give support to families during pregnancy, early infancy, and early childhood:

Families and Schools Together Program: This is a drug and alcohol abuse prevention program for at-risk children. Groups of families participate in this highly structured eight week program which includes two years of follow-up activities.

Mothers and Sons Program: This program targets single mothers and their sons focusing on family responsibility and community involvement. The program includes family preservation services, classroom/group training, and family support networks. The target population specifies boys aged 10-14 who have had school suspensions, or who have been identified as being involved in gangs, bullying, or minor vandalism.

First Offenders and Family Preservation Program: This program provides intensive family counseling and social work services. The caseload ratio is one social worker per five families for a three to four month period. In addition, case aides provide follow-up and supportive services for six months following caseworker interventions. The social worker assigned to each family spends approximately five to seven hours with each family weekly and is available to the family 24 hours a day, seven days a week.

After School Program: This program provides support and supervision to youth and respite time to parents. The program operates in partnership with existing community programs emphasizing recreational and educational components.

The total cost of the Juvenile Crime Initiative programs including State support is $10 million per year. Costs are borne by the General Fund.

Options For Recovery Pilot Project

This program was established in 1989 as a pilot project in which foster parents are recruited and trained to provide specialized care in a family home setting for foster children born with health problems related to substance-exposure or to HIV exposure. Parents are provided with respite care and receive specialized training in the health care needs of children born substance-exposed or with AIDS. The intent of the program is to provide a placement option for these children that is less expensive and more home-like than a group home or other institutional residential placement.

Federal matching funds are available at the rate of 75 percent for training costs and 50 percent for recruitment costs. Respite care costs do not qualify for federal funding. All non-federal costs are shared between the State (70 percent) and the counties (30 percent). The total 1996-97 budget for the program is $6.4 million ($3.7 million General Fund / $1.1 million federal funds / $1.6 million county funds).

WrapAround Services Pilot Project

This is a program operated by Santa Clara County in which foster children in high-level group home placements are taken out of placement and provided intensive wrap around services so that they may be reunified with their families. It was authorized by AB 2297, which was enacted in 1996. Wrap-around services are individually tailored and designed to build upon the strengths of the child and the family. Each case is assessed by an interdisciplinary team of professionals who determine the particular needs of the family and develop a case plan to address the issues which brought the family into the child welfare system.

Funding for the program is from Santa Clara County's Foster Care allocation. The program is limited to 125 cases with a monthly reimbursement rate of $4,719 to pay for the services. The reimbursement rate is based upon the average cost of high-level group home placements (rate level 12 and above). Assuming that the State's Title IV-E waiver is approved, Federal Title IV-E funds will be available at the rate of 50 percent for federally-eligible cases and all non-federal costs will be divided between the State (40 percent) and the county (60 percent). The 1996-97 budget for the program totals $7.1 million ($1.9 million General Fund / $2.4 million federal funds / $2.8 million county funds).

Youth Pilot Project

In 1993, AB 1741 established the Youth Pilot Project to allow six selected counties (Alameda, Contra Costa, Fresno, Marin, Placer and San Diego) to test whether local communities could better serve children and families if categorical funds were integrated. AB 1741 allows pilot counties to blend funds from various child and family service programs in an effort to provide comprehensive, integrated services to children and families. Collaborative or integrated service delivery models focus on the use of multi-disciplinary teams to assess the needs of children and families coming into the system and providing services in a coordinated manner. In this way, programs attempt to minimize duplication in case management and service delivery and maximize the use of program resources. Additionally, by decategorizing program funding, the program will provide flexibility in the provision of services and program administration. Although AB 1741 did not appropriate any new funding for the pilot counties, it permitted the blending of existing funding sources and required the State to seek federal waiver to permit the blending of federal funding streams.

Issues/Problems With Current Funding Structure

Our review of the funding structures of child welfare programs identified several concerns with the manner in which programs are currently funded. As previously indicated, there are a wide array of child welfare programs. Each program seeks to achieve a desired programmatic outcome for the children and families that it serves. One of our key concerns regarding program funding is whether the program financing structures facilitate or impede the achievement of program goals and desired outcomes. Several components of the funding structure (e.g. funding levels, cost sharing ratios, funding formulas, type of funding authorization) have the potential to positively or negatively impact a program's ability to achieve its objectives.

Cost Sharing Ratios

Varying cost sharing ratios among different programs can provide incentives for certain behaviors by the way they interact. This is an issue that affects both the Adoptions Program and the Foster Care Program.

Adoptions

In some instances, the interaction between the cost sharing ratios of different programs facilitates the achievement of programmatic objectives. The Adoptions and AAP programs

provide a good example. The AAP program is an entitlement program which provides monthly cash grants to families that adopt children with special needs that make them relatively difficult to place in adoptive homes. The primary objective of the AAP and the Adoptions programs is to secure adoptive families for children that will never be reunified with their biological families due to serious issues of abuse or neglect, or parental inability to provide a suitable home environment for the child. The vast majority of these children come from long-term foster care or permanent out-of-home placement.[147] Accordingly, a secondary objective of this program is to get children out of long-term foster care or other out-of-home placement.

As an entitlement, AAP is assured of an open-ended funding stream. Accordingly, if a county places more special needs children in adoptive homes, more funds will be made available for the program. Additionally, the cost sharing ratios also support the goal of more adoptions. Counties, which are responsible for making placement decisions, do not have a share of costs in the Adoptions program. In the AAP program, counties are responsible for 25 percent of the non-federal share of program costs. Additionally, monthly AAP grants are lower than foster care grants. For the 1996-97 fiscal year, the average monthly foster care grant per child is estimated to be over $1,200 per month while the average monthly AAP grant is approximately $450 per child.[148] While a child is in foster care, counties fund 60 percent of the non-federal share of the foster care payment, as well as 30 percent of the non-federal share of the costs of any needed child welfare services. Through the AAP program, counties fund only 25 percent of non-federal share of a much lower monthly grant. Accordingly, counties have a fiscal incentive to move children out of long-term foster care and into adoptive homes. In this case, the funding structure provides an incentive which promotes the goal of moving special needs children out of long-term foster care and into a permanent home with an adoptive family.

Kinship Foster Care

Typically, children in kinship placements receive either AFDC or foster care grants. In California, as of November 1996, there were approximately 104,500 children in out-of-home placements. Of these, an estimated 49,500 were placed in the home of a relative. If a child is federally-eligible for foster care, the child will receive a foster care grant. Of the 49,500 children in kinship placements, approximately 25,700 receive foster care grants. In 1996-97 the average foster care grant for a placement in a family home is $541. The federal government pays $271 (50 percent) of this grant, with the State and the county dividing the remainder of the costs 40 percent ($108) and 60 percent ($162) respectively.

[147] Ibid.
[148] California Department of Social Services, Local Assistance Estimates for the 1997-98 Governor's Budget, 1997, Auxiliary Tables, p. 1.

However, in cases where the child is not federally-eligible, the child will instead receive an AFDC grant. Approximately, 21,000 children in kinship placements receive AFDC grants. In those cases, where a child receives an AFDC grant, the funding ratios provide an incentive for a county to keep the child in long-term kinship care rather than moving the child to a permanent placement such as adoption. The average AFDC grant level in 1996-97 is $511. The federal government pays 50 percent ($256) of this amount. The State pays 95 percent ($243) of the remaining costs and the county pays 5 percent ($12).

If a child is placed for adoption the county pays no share of the adoptions costs. However, the child would likely qualify for AAP. The 1996-97 average AAP grant is approximately $450. Because the case would be a non-federally-eligible case, the State would pay 75 percent ($337) and the county would pay 25 percent ($113) of the costs. Accordingly, the county has a fiscal incentive to keep the child in a kinship placement. This would appear to be contrary to the overall goal of moving children from out-of-home placement and into permanent homes.

Capped Entitlements

The nature of a program's funding authorization can impact the program's effectiveness. Some programs are funded through capped entitlements, others through open-ended entitlements, and others through grants. The interaction between programs with different types of funding authorizations can adversely impact achievement of desired programmatic outcomes. This is an issue that affects the Foster Care, CWS and Independent Living Programs.

Foster Care and CWS

The Foster Care program and the CWS program are intended to: 1) protect children from abuse and neglect; 2) provide alternative living arrangements for children that cannot be safely maintained in their homes; and 3) address the issues that caused removal of the child so that the family may be reunified as quickly as possible. However, the funding structures for these programs can make it fiscally advantageous for counties to keep children in foster care rather than providing the services needed to reunify the family.

Both CWS and Foster Care qualify for federal funding. However, the cost sharing ratios favor providing services over out-of-home placement as counties pay 30 percent of the non-federal share of CWS costs as compared to 60 percent of the non-federal share of Foster Care costs. Additionally, it is generally more costly to maintain a child outside of the home rather than provide services and treatment that would allow a child to remain or return to a safe home environment.[149] However, Foster Care funding is an open-ended entitlement, while

[149] U.S. Congress, Ways and Means Committee, 1994 Green Book: Overview of Entitlement Programs, Washington, D.C.: U.S. Government Printing Office, 1994, Section 14, p. 1.

funding for the services provided through CWS is capped. Consequently, if a county's CWS expenditures were to exceed its CWS allocation, the county would be responsible for funding 100 percent of the non-federal share of any costs that exceed the CWS allocation. This is called county overmatching.

Counties that must overmatch can find themselves in a real dilemma if they are experiencing budgetary shortfalls. If a county's efforts at keeping children out of foster care result in a higher than anticipated number of children moving onto the CWS caseload, the county may find itself in a situation where it must overmatch its CWS allocation. For example, a county could decide to review the status of children in long-term Foster Care placements and as a result, children might be moved out of placement and provided services which allow them to remain in the home. If a county is not in a position to fund an overmatch, it must either provide a lower level of CWS services (e.g., a county might reduce the frequency or duration of services such as anger management counseling for abusive parents or reduce in-person responses to child abuse reports), increase the caseloads for county social workers or leave children in foster care. Given that a county might have to fund 100 percent of the non-federal costs of a CWS case versus 60 percent of the non-federal cost of a Foster Care case, the funding structure appears to provide a disincentive to counties in achieving the goal of promoting services in the home rather than placement out of the home.

Independent Living Program

The Independent Living Program (ILP) provides an additional example of a program in which a capped entitlement funding structure may impede achievement of the program's goals. Through ILP, services are provided to transition older adolescent foster children to independence and self sufficiency as they emancipate from foster care. The goal is to make these children independent as adults. As productive and self-sufficient adults, these individuals should avoid becoming dependent on other public benefits such as AFDC or unemployment, or becoming a responsibility of the taxpayers through other publicly-funded systems such as the justice or state hospital systems. However, whereas Title IV-E provides an open ended entitlement for these children while they are in foster care, funding for services to transition foster children to independence is capped. Accordingly, not all of the children emancipating from foster care can receive ILP services.

Funding Formulas

Another important component in a program's funding structure is the funding formula which determines the level of funding for a program. An inappropriate funding formula can undermine a program's effectiveness. This is an issue that affects the State Family Preservation Program.

State Family Preservation Program

The funding formula for the State Family Preservation Program (FPP) created a fiscal quandary for counties and threatened to undermine the very program it was intended to support. The FPP was established in 1988 as a pilot program at a time when foster care caseloads where growing at an unprecedented rate. The program was intended to provide an alternative to foster care by utilizing foster care funds to provide intensive short-term services which would enable families to stay intact. Hence the name Family Preservation Program. The funding formula for counties wishing to participate used a moving average of actual caseload costs for the previous five years. This moving average was used to project future foster care expenditures and pilot counties were advanced up to 25 percent of projected foster care expenditures. Savings (or deficits) were then calculated as the difference between projected foster care caseload expenditures in the absence of FPP and actual county expenditures with FPP and foster care. Pilot counties were allowed to retain any identified savings generated through the FPP. However, if the counties were in a deficit, penalties were assessed against the county.

Two factors combined to make this formula work against the pilot counties. After initiation of the FPP pilot, foster caseload growth slowed dramatically. As this occurred statewide, the slow down could not be attributed to FPP. This had an adverse effect on pilot counties because their expenditure targets were established based upon caseload projections that anticipated a steep growth trend for foster care caseloads. However, by the time the counties had to account for their performance, their expenditure patterns were being compared to projections that were based upon a flatter caseload growth. Secondly, the funding formula based future funding upon a caseload which the FPP was attempting to reduce. As FPP funding levels for future years were determined as a percentage of projected foster care expenditures, to the extent that FPP counties were successful in keeping children out of foster care, they were further reducing the FPP budget for future years. In this case, the funding formula for FPP did not support the program's objectives.

Several measures were undertaken to attempt to address the inequities in the funding formula and to help counties avoid being penalized. Counties were allowed to freeze the level of funding for FPP by moving out of the pilot phase of the program and requesting a permanent transfer of foster care funding. This provided some relief, however, there was an adverse impact to the program. The amount of the permanent transfer was limited to no more than 70 percent of the level of FPP funding advanced to the county during its pilot phase. Additionally, counties seeking permanent funding were required to provide a 30 percent county match. For counties that remained in the pilot phase, the methodology for determining FPP funding levels was revised to use the caseload trends for the five years preceding the county's entry into the pilot. These measures did alleviate some of the problems. However, some counties unwilling to risk being penalized have dropped out of the program and all but one county have requested to be moved from the pilot phase to the permanent transfer phase of the FPP.

Other Issues

During our county visits, we received reports that some counties were losing Foster Family Homes (FFHs) to Foster Family Agencies (FFAs). In some counties, we heard that virtually all foster families were affiliated with FFAs. As we noted in Chapter 1, the data from the Foster Care Information System does show that the number of children in FFAs has increased by approximately 500 percent between 1989 and 1995. Upon preliminary examination, it appeared that the differential rate structure may have been a major cause for the shift. For example, FFHs receive from $345 to $484 per month per child, depending on the child's age, whereas FFAs receive between $1,283 and $1,515 per month for the same child. However, FFHs also can qualify for a specialized care increment if the increment is part of the county's foster care plan that has been approved by the Department of Social Services.[150] The specialized care increment averages $305 across the State. On the other hand, if an FFH affiliates with an FFA, the foster family receives only the basic rate for FFHs and a maximum monthly allocation of $175 to cover additional child care and supervision.

Although the differential rate structure itself may not be a factor in attracting foster families to FFAs, the additional case management provided by FFAs may be a reason for the shift. Part of the difference in FFH and FFA rates is an amount to cover the additional administrative costs of the FFAs and to recruit and train the operators of their certified family homes. The administrative allotment includes $250 per child for the cost of social workers who are employed by the FFA. Some FFAs provide respite care for the families affiliated with them, and, according to many county staff, FFAs tend to provide more caseworker visitations than the county can afford to provide. Furthermore, FFAs use some of their administrative cost allocations to actively recruit FFHs. It is possible that the increased case management services provided by the FFAs, which are encouraged by the rate structure, create an incentive for foster families to join FFAs and for case workers to refer more foster children to FFAs than is merited by the children's problems alone. While we have no evidence to demonstrate this is occurring, we believe it is worth examining.

EFFORTS TO ADDRESS PROBLEMS WITH PROGRAM FUNDING STRUCTURES

State-Local Realignment

In 1991, the State-Local Realignment Program was enacted in response to growing concern about the ability of counties to fund health and welfare programs and the inappropriate fiscal

[150] In one county we visited, the county pays as much as $529 for specialized care. The county reported that it was not losing FFHs to FFAs.

incentives created by program cost sharing ratios. Realignment provided counties with $2 billion in funds for a variety of health and social services programs. Additionally, Realignment revised the county cost sharing ratios for certain social services programs in an effort to eliminate incentives for cost shifting. Prior to Realignment, programs such as Foster Care and CWS had very uneven cost sharing ratios. Local fiscal pressures often caused counties to place an emphasis on providing services to clients based on who paid for the program. For example, prior to Realignment, counties had only a 5 percent share of costs in the foster care program. Accordingly, this provided a substantial fiscal incentive for counties to place children in foster care rather than providing services in the home because counties had a lower share of costs in the Foster Care program.

The State-Local Realignment proposal began to address this issue by more closely aligning county sharing ratios among similar programs. Realignment also encouraged counties to experiment with coordinated and collaborative approaches to funding and delivering services, recognizing that individuals often receive services from several different, but closely related, programs. The Realignment proposal also provided a dedicated and stable revenue source for counties to fund programs. In addition, it provided counties with flexibility and financial incentives to make decisions based on client needs, rather than fiscal advantage.

Realignment Proposal II (1994-95)

The Administration presented a second realignment proposal in the 1994-95 Governor's Budget. The proposal recognized that in spite of the improvements brought about by the State-Local Realignment program, funding for programs was still categorical in nature. Further, at the State level, program oversight focused on the process used to deliver services rather than on whether programs were achieving desired outcomes. Accordingly, the 1994-95 proposal was an attempt to provide more local control over programs, eliminate inappropriate fiscal and program incentives and establish fiscal incentives for performance. The proposal would have transferred a percentage of the State sales tax to a new Children's Services Subaccount within the existing Realignment funding framework. With this additional resource plus the revenues allocated to counties in the 1991 State-Local Realignment program, counties would have become responsible for 100 percent of the non-federal share of costs for the Adoptions, AAP, CWS and Foster Care programs. The proposal ultimately failed to pass the Legislature due to county concerns about losing the safety net of State participation in entitlement programs such as Foster Care and AAP.

Title IV-E Waiver Request

In 1994, the federal government announced that for the first time it would allow states to submit waiver requests for Title IV-E programs such as Foster Care and AAP. In an effort to address concerns regarding funding for children's programs and test innovative ways of

serving children and families, the State submitted a three-part waiver request in November 1996. The first component would allow an extension of the time during which foster care payments can be made for voluntary placements. The second component would allow foster care payments to continue for kinship care placements in cases where the relative seeks legal guardianship. The third component would allow for the use of Title IV-E funding for the costs of services to divert children in placement to lower levels of care or to avoid placement altogether.

The third component of the waiver package is probably the most significant in terms of addressing the issues regarding the current funding structures for child welfare programs. The prohibition on the use of Title IV-E funds for services has hindered the State's and counties' ability to provide the level of services needed to protect children from abuse or neglect. If approved, the waiver proposal could open the door to focusing program resources on front end efforts such as early intervention and prevention services.

ALTERNATIVE FUNDING STRUCTURES

As indicated in our discussion above, we believe the method of funding the child welfare system is seriously flawed. Although there have been several attempts to modify the funding formulas to improve the situation, these attempts have either failed to be enacted or they have addressed the problem only at the margin. We believe these problems must be addressed in a comprehensive manner if the system is to operate effectively. Consequently, we believe the Administration and the Legislature should consider alternative ways of funding the system. Below, we present several alternatives for consideration.

Realignment II/Flexible Funding

Since the 1991 implementation of Realignment, counties have expressed an interest in an allocation system that allows flexible use of funding for what are now categorical programs. Several efforts such as the AB 1741 Youth Pilot project, Family Preservation Program and the AB 2297 Wrap-Around Services Pilot project have attempted to provide counties an opportunity to test their ability to reduce child abuse and neglect through the use of flexible funding. A flexible funding structure would allow counties to focus resources on prevention and early intervention services as an alternative to more expensive interventions such as Foster Care. Accordingly, in considering alternative funding structures, providing counties with flexibility in the allocation of resources should be a prime concern.

The Administration's 1994-95 Realignment proposal would have transferred a percentage of the State sales tax to the counties via the funding framework established in the 1991 Realignment program. Counties would have become responsible for 100 percent of the non-federal share of cost for the child welfare programs. The State's oversight role would then

have shifted away from ensuring compliance with process-oriented regulations to ensuring the achievement of desired programmatic outcomes. The proposal would have provided counties both the ability to restructure programs at the local level and a stable and growing funding source to meet the needs of children and their families. There are several factors which make a restructuring proposal attractive:

- Counties Control the System - The counties, as the front-line administrators of child welfare programs, are in the best position to reform and restructure the child welfare system. Counties conduct child abuse investigations, assess the needs of children and families that come into the system, develop the treatment and service plans for clients of the system, make placement decisions and represent the system before the courts during all judicial proceedings. The State attempts to influence each of these aspects of the system through the promulgation of policy and regulations. However, even then counties are the ones that implement those policies. The State's oversight role principally focuses on ensuring compliance with process-oriented requirements. Even when the State reviews county practices in programs such as foster care or CWS, the review is an after-the-fact examination.

- Elimination of Disparate Funding Ratios - As pointed out previously, the varying cost sharing ratios among programs can provide incentives for behavior that is inconsistent with programmatic goals. Giving the counties responsibility for 100 percent of the costs not covered by the federal government for all programs would eliminate counterproductive fiscal incentives.

- Counties Could Restructure Local Programs To Meet Local Needs. - The State having principal responsibility for programs such as CWS and Foster Care creates the illusion of a uniform statewide program design and administration. In fact, even though program policies for these programs are promulgated at the State level, there is little consistency among counties in the way those policies are implemented. In effect, you have 58 different child welfare systems. The Realignment proposal would acknowledge this dynamic and make it more effective by also shifting decisionmaking on the allocation of resources to best meet the needs of each community to the county level.

- Counties Would Bear The Consequences Of Their Decisions. - Under the existing program structure, even though the counties make all of the decisions on how programs are administered, the State bears part of the consequences of counties' decision-making. For example, if a county decides to implement a policy which increases the length of stay of children in Foster Care, the General Fund is obligated to fund additional costs for that county. Under the Realignment proposal, counties would bear the responsibility for county decision-making.

Implementing a second Realignment proposal would provide both the resources and flexibility counties need to operate the children's services programs. As importantly, the

proposal would also promote increased local control and responsibility, as well as appropriate fiscal incentives for program results. One significant concern is the need to ensure that counties comply with federal requirements. Currently, if the federal government determines that programs are out of compliance with requirements for the receipt of federal funds, they will disallow program costs and require the State to repay disallowed costs. Once counties become responsible for all non-federal costs, they should also bear responsibility for repayment of federal disallowances. This could be accomplished by offsetting future allocations of sales tax revenues by the amount of federal disallowances.

Block Grants

The State could provide block-grant funding to counties for child welfare programs. A block grant would consolidate individual funding streams into a single funding stream that would be subvened to counties. By decategorizing the various individual funding streams and by eliminating many of the regulatory strings attached to the receipt of those funds, a block grant would provide the counties greater discretion in the structuring of programs and allocation of resources. Counties would have the flexibility to focus funding on programs at the front end of the child welfare system. In exchange, counties would assume full responsibility for funding programs and serving all clients that come into the system within the resource base provided by the block grant.

Implementation of a block grant could address county concerns regarding the prescriptive and restrictive nature of the existing funding structure and the State's concern over growing program costs and the efficient and effective use of resources. However, any block grant proposal would need to address several concerns:

- Development of a new allocation methodology at the State level. Currently, program funding is allocated to counties on the basis of program caseloads and defined workload standards. Under a block grant environment, program designs and workload standards would vary widely between counties. Accordingly, the existing funding allocation methodologies would no longer be appropriate. As an example of an alternative allocation methodology, block grant funds could be allocated to counties on the basis of child population.

- Development of an accountability mechanism by which counties could be held accountable for serving the needs of children and their families. The State's existing oversight function is heavily focused on process. For example, cases are reviewed to see how often a social worker met with a child, or whether mandated actions took place within specified time frames. Under a block grant environment, such measures would be less meaningful. The State would have to move to other indicators of program

effectiveness (e.g., rate of child deaths in a county or the percentage of the child population in out-of-home placement).

- Ensuring compliance with federal requirements. Although implementation of a block grant would eliminate many of the regulatory strings at the State level, federal requirements would remain intact. Some of these, such as restrictions on the use of federal funds or cost claiming requirements, could hamper county efforts to reform and restructure child welfare programs. Provisions would have to be made to both ensure that counties complied with federal requirements and to seek relief from overly restrictive federal requirements that would impede efforts to make the child welfare system more efficient and effective.

- Ensuring counties have sufficient resources to fund entitlement programs. This would perhaps be the counties' biggest concern. Programs such as Foster Care and AAP currently have federally-established entitlements. Implementation of a block grant at the State level would not change that. However, even if the block grant included provisions for future growth, counties might not want to bear the full responsibility of funding costs in entitlement programs without some assurance that block grant revenues would be sufficient to fund growth in those programs. If counties are not satisfied that this concern would be addressed, it is unlikely that any block grant proposal would move forward.

An alternative form of block grant could be devised so that the entitlement components of the Foster Care and AAP programs are excluded. In this way, the State could maintain its participation in the entitlements and address county concerns about having a fiscal safety net for entitlements. However, we would not advocate such a model because it would defeat the purpose of a large grant by providing an incentive for cost shifting.

Outcomes-Based Budgeting

Another recent trend in the public sector has been the implementation of performance- or outcomes-based budgeting. This budgeting strategy allocates resources based on an expectation of performance levels where performance is measured in terms of achievement of specified outcomes. In linking desired program outcomes and resource allocation, outcomes-based budgeting provides rewards or penalties to programs based on their success in achieving desired program outcomes.

In 1993, California began to move towards performance-based budgeting in the development of the State budget. This represented a shift from traditional workload budgeting practices. This same concept could be applied in the funding of child welfare programs which are currently funded based on changes to program caseloads. Outcomes could include the prevention of child abuse, removal of children from foster care placements, increase in the number of adoptions, etc. This structure would allow program administrators the flexibility to

allocate program resources to best meet the needs of children and families that come into the CWS system. Outcomes could be tracked to determine whether goals have been met. Unlike the traditional caseload-based funding structure where as a consequence of finding ways to reduce child abuse or out-of-home placements, program administrators can find their program budgets reduced, administrators in outcomes-based funding structure can be rewarded for innovation.

- Appropriate Outcome Measures - The difficulty in an outcomes-based funding structure would be the development and measurement of outcomes by which counties could be held accountable. For such a structure to be successful, results must be agreed upon and measurable. As pointed out earlier, universal agreement on programmatic outcomes or on a consistent method of measuring outcomes is lacking. Getting counties to agree to be accountable for specified outcomes and on the manner in which performance will be measured would be vital to the success of such a funding structure and would be a significant undertaking.

- Consequence of Poor Performance - The second part of holding counties accountable would be determining an appropriate consequence of failure. In other words, what would happen if a county failed to achieve an agreed-upon level of performance? In other systems, under outcomes-based budgeting, if a program fails to achieve an expected level of performance, the administering agency is sanctioned. The sanctions could include loss of funding or loss of decision-making authority. Could either of these types of sanctions be applied in the child welfare system? For example, if a county failed to achieve an agreed upon outcome (e.g., reducing a specified number of children from the foster care caseload) could funding for that county's Foster Care program actually be reduced? In fact, the opposite might occur: the county might get additional funding to address the higher foster care caseload. Accordingly, in designing an outcomes-based funding structure for the child welfare programs, appropriate incentives and consequences would need to be developed.

Managed Care

Another trend in public programs that offer services to clients is the increasing use of managed care models. For example, California has implemented some form of managed care in its Medi-Cal, Mental Health and In-Home Supportive Services (IHSS) programs. Under managed care, costs of programs are controlled because program administrators have a fiscal incentive to identify and treat problems early, insure that clients receive only those services that are needed and for only as long as necessary to remedy the identified problem. Under managed care, the programs receive a capitated or negotiated fee for clients. Some of the clients will have relatively little need for services while others will require extensive treatment. Programs are expected to manage and allocate resources in the most efficient and effective manner while still providing competent treatment to clients in need. Programs

assume some degree of financial risk, however, they also have a significant degree of control over costs.

Managed care has been looked to as a potential solution to the growing costs of child welfare programs. However, there are some key differences between the child welfare programs and other fields that must be considered in undertaking a managed care approach.

- Clients of the child welfare system are not voluntary - In the medical and mental health systems, clients are motivated by their own health concerns to seek out treatment and follow-through with prescribed treatments. In the child welfare field, clients do not come to the system voluntarily and are often resistant to the services offered. It is not uncommon for clients to fail to follow through on prescribed treatments.

- Program administrators have limited control of factors that affect client outcomes - In the medical and mental health fields, the treatment process focuses on the individual. In the child welfare system, treatments often cannot be limited to an individual. Often symptoms are rooted in larger problems such as domestic violence, poverty, or parental substance abuse. Program administrators often have limited ability to eliminate the conditions which cause the problems. Additionally, treatments often have to be approved by the courts which may or may not concur with the prescribed treatment plans.

- There are no uniform diagnostic or treatment protocols - In the medical and mental health systems, there is at least general agreement regarding symptoms, diagnoses and treatments. As indicated in this report, in child welfare programs there is no universal agreement on assessment of symptoms or prescribed treatments. Further, there is little empirical data to demonstrate a link between treatments and anticipated outcomes.

- There are weaknesses in the system that could undermine the success of managed care - In the current system, service providers do not bear responsibility for the success of the programs. Currently, most of the services provided to clients are purchased from private-sector providers. Yet when the system fails and a child is abused or a child death occurs, the child welfare system bears the responsibility.

State Takeover of Program Services

In some states, child welfare programs are operated at a state level and the states assume full responsibility for administering and funding the child welfare system. Could such a structure work in California? State-level program operation might provide for more uniformity of services and program design. Additionally, it might provide more consistency in the standards used to assess child abuse or neglect. Child welfare workers, under a State-operated system, would receive a standardized training program and be held to consistent standards in providing services to clients of the child welfare system. Additionally, a funding structure in

which the State funded all costs not covered with federal funding would eliminate counter-productive fiscal incentives.

A State takeover of child welfare programs, however, would be a fundamental shift in the way programs have been administered. Additionally, it would be a radical departure from the Administration's philosophy of increased local control and reduced State bureaucracy. The Administration's position has been that local governments are in the best position to provide program services that are responsive to the needs of local communities. A monolithic State bureaucracy would be less responsive to those needs. In our judgment, concerns about the State's ability to meet the needs of local communities would cause counties to resist State efforts to take over the programs.

CONCLUSIONS AND RECOMMENDATIONS

Our review of the funding structures of the child welfare programs lead to several conclusions:

- The current funding structure does not always support, and at times contradicts, the programmatic objectives of child welfare programs.

- The current funding structure denies program administrators the flexibility to focus program resources on interventions and services that could lead to the prevention and early detection of child abuse and the preservation or reunification of families.
- The current funding structure does a better job of funding the costs of removing children from their homes than funding the services and treatments that would help to keep children in the care of their families.

- The issues identified with the current funding structure prevent the child welfare system from operating at an optimal level of effectiveness.

- Potential alternatives (some of which have been modeled) to the current funding structure have the potential to address some of the shortcomings in the existing funding structures. However, each alternative has its own set of issues which must be addressed.

Although our report is not intended to be an exhaustive review of all the issues and concerns with the current funding structure, we have attempted to provide a useful discussion of some of the more significant funding issues. In our judgment, the child welfare system can reach an optimal level of functionality in protecting children from abuse and neglect and helping families to address the causes of child abuse and neglect only if these fiscal issues are addressed.

We believe that the best way to address these issues is by giving counties additional responsibility for the child welfare system and a source of funds with which to carry out those responsibilities. *Therefore, we recommend that the Administration and Legislature move forward with a second Realignment proposal patterned closely after the Realignment proposal included in the 1994-95 Governor's Budget.* Implementation of the proposal would provide counties both the authority and the resources to reform and restructure programs to best meet the needs of the local community. Additionally, counties would have flexibility to allocate resources to the front-end programs that reduce the need for out-of-home placements without the inappropriate fiscal incentives which hamper current efforts. Finally, by providing a stable and growing funding base, the proposal would address county concerns over having full responsibility for entitlement programs.

In the absence of such a proposal, we would recommend that immediate efforts be undertaken to change some of the funding formulas and cost sharing ratios which impede the achievement of desired programmatic outcomes. Specifically, we would recommend the following:

- *The cap on funding for services through the CWS program should be eliminated.* This would eliminate the need for county overmatching and the incentive for county cost shifting by maintaining children in Foster Care. *Similar changes should be sought at the federal level.*

- *The IV-E waiver proposal before the federal government should be amended to include a proposal to enable Foster Care entitlement funds to be used for independent living services and training for children preparing to emancipate from Foster Care.*

- Under federal welfare reform, funding for AFDC grants for non-federally eligible children placed in kinship care will now come from State funds (General Fund and TANF) and county funds. *State law should be changed to allow these cases to instead receive a foster care payment*. The monthly grants are similar in amounts, however, the current cost sharing ratios mean that counties only pay 5 percent of an AFDC grant versus 60 percent of a Foster Care grant. This provides counties an incentive to keep children in long-term kinship care rather than placing children in adoptive homes.

APPENDIX A
MATRIX OF INDICATORS
FOR CHILD WELFARE PROGRAMS[151]

TARGET OUTCOME: CHILD SAFETY. Children are safe in biological homes, in out-of-home care, and as residents of the community.

Child Focused

- Percentage of child welfare cases with a subsequent substantiated report of child abuse and neglect for any child in the home:
  a. within a given time frame following the initial substantiated report.
  b. while open for child welfare services.
  c. for families involved in prior unsubstantiated cases of child abuse and neglect.
  d. within a specified period of time following case closure.
- Child's sense of safety and security.
- Incidence of preventable serious injuries or fatalities resulting from child abuse and neglect.
- Adjudicated delinquency rates for youth receiving child welfare services.
- Percentage of adjudicated youth open for child welfare services that successfully complete probation.
- Percentage of youth open for child welfare services with parole or probation revocation.
- Percentage of youth returning to community from youth centers who re-offend within 6 and 12 months of release.

Family Focused

- Parents' knowledge of children's physical and developmental needs.
- Incidence of domestic violence in families receiving child welfare services.

Community Focused

- Community risk factors contributing to child maltreatment (e.g., economic stress, dissolved families, violence).

[151] Source: Matrices of Indicators prepared for The Fourth Annual Roundtable On Outcome Measures in Child Welfare Services, May 16-18, 1996 San Antonio, Texas. Co-sponsored by the American Humane Association and the National Association of Public Child Welfare Administrators, an affilate of the American Welfare Association.

TARGET OUTCOME: CHILD FUNCTIONING. Developmental needs are met. Education, training, and/or employment needs are met. Social, cultural, and identity needs are met. Behavioral, emotional, and health needs are met.

Child Focused

- Children live in safe, permanent homes reflective and respectful of the child's cultural, ethnic, racial, and kinship identity.
- Percentage of children whose physical and mental health is maintained or improved.
- Child reaches appropriate developmental milestones.
- Parents' awareness of how their behavior impacts their children.
- School performance for children:
  a. receiving child welfare services.
  b. within a specified period following case closure.
- Child's connection to family and community.
- Number of incidents of discipline problems among children receiving services and after case closure.
- Percentage of adolescents in care.
- Percentage of youth:
  a. aged 18+ years who live independently.
  b. who obtain full- or part-time employment
  c. who attend college and/or job training.
  d. who have no contact with public assistance or criminal justice within specified time frames.

Family Focused

- Quality of parent/child interaction.

TARGET OUTCOME: FAMILY FUNCTIONING. Developmental needs are met. Education, training, and/or employment needs are met. Social, cultural, and identity needs are met. Behavioral, emotional and health needs are met. Environmental/housing needs are met.

Child Focused

- Child and parents have quality interactions and improved attachment.
- Children enjoy parents.
- Children are socially well-adjusted.

Family Focused

- Incidence of family violence while open for child welfare services.
- Families use of illegal drugs/substance abuse.
- Parents provide for family members:
  a. health care
  b. nutritious food
  c. housing
- Families ability to meet basic needs, including:
  a. an ability to afford a variety of foods.
  b. having enough appliances, utensils to prepare food in a variety of ways.
  c. housing of choice.
  d. spending less than 20% of income on shelter.
  e. feeling safe and secure in home and neighborhood.
  f. having mutually agree-upon rules and expectations.
  g. having sufficient money to allow for spending choices.
  h. ability to pay bills on time and manage debt load without depriving the family.
- Families involvement in the community.
- Families have adequate vocational skills to advance in career.
- Families are employed in business offering basic benefit package.
- Families have an established relationship with a financial institution.

TARGET OUTCOME: FAMILY CONTINUITY/PRESERVATION. Children will reside safely in their own homes. When children cannot safely reside in their own homes, they will maintain stable, permanent family and kinship ties.

Child Focused

- Percentage of children who remain safely in the home:
  a. while open for child welfare services.
  b. within a specified timeframe following case closure.

- Percentage of children in out-of-home care who are placed:
  a. with family or kin providers.
  b. with siblings.
  c. within the community of origin.
  d. within the school district of origin.
  e. within the county of origin.

- Number of placements per child.

- Percentage of children placed in out-of-home care with goal of return home:
  a. who return home.
  b. whose goal is changed to permanent out-of-home placement.

- Average length of stay for children:
  a. in nonpermanent out-of-home placement.
  b. between first temporary out-of-home placement and permanent placement.
  c. in out-of-home care by placement type.
  d. in out-of-home care by permanency goal.

Family Focused

- Frequency of face-to-face contacts between children in out-of-home placement and their families.

APPENDIX B
OUTCOMES FOR CHILD WELFARE SERVICES
as drafted by
A STATE/FEDERAL COLLABORATIVE[152]

FOCUS AREA 1: Improved outcomes for children and families already in the child welfare system or a high risk of entering the system.

Category I Child Safety and Health

Children are safe.
Children are healthy.

Category II Child Functioning

Improved child functioning.
Children are ready to enter, achieve, and participate in school.
Increased capacity for self-sufficiency.
Reduced number of children entering Juvenile Justice system.

Category III Family Functioning

Families are safe.
Parents provide a stable environment for children.
Minor parents parent appropriately.
Parents have adequate income.
Families in crisis and at risk of losing their children are strengthened.
Improved functioning of other family members.

Category IV Customer Satisfaction

Clients are satisfied with services provided.

[152] Center for the Study of Social Policy, State/Federal Collaborative For Comprehensive Child Welfare Information Systems Development Outcome Analysis, Draft, April 1995.

FOCUS AREA 2: Improved child welfare system.

Category I System Inputs (resources and staffing)

Improved gatekeeper function.
Have resources ready for child.
Increased quality adoptive and foster homes.
Quality legal representation for child.
Culturally sensitive foster care.
Culturally competent services provided.

Category II System Outputs (preservation, reunification, placement)

Families preserved increased.
Children placed as soon as possible in a stable, quality, permanent home.
Out-of-home placement is in relative home or in the same neighborhood as birth parent(s).
Reliance on institutional or congregational care is reduced.
Length of stay of children in out-of-home care is reduced.
Multiple placements are reduced.
Increased reunifications consistent with permanency goal.
Disrupted adoptions reduced.
Adoptive and foster home retention increased.

Category III Information System Capabilities

Data bases that capture foster care resources by geographical areas.
Ability to identify class members.

APPENDIX C
DATA & SOURCES FOR NATIONAL COMPARISON

TABLE C-1
CHILD POPULATION OF LARGEST STATES, 1994

State	Size of Population Under 18 Years of Age
California	8,677,000
Texas	5,301,000
New York	4,511,000
Florida	3,262,000
Illinois	3,083,000
Pennsylvania	2,898,000
Ohio	2,854,000
Michigan	2,525,000
New Jersey	1,931,000
Georgia	1,893,000
North Carolina	1,756,000
Virginia	1,603,000

SOURCE: U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect, Child Maltreatment 1994: Reports From the States to the National Center on Child Abuse and Neglect, Washington, DC: Government Printing Office, 1996.

TABLE C-2
CHILDREN REPORTED AS ABUSED AND NEGLECTED, 1994
States in Descending Order of Children Reported per 1,000 Children in the Population

States	Children in the Population (Estimated)	Children Reported as Abused and Neglected	Children Reported per 1,000 Children in the Population
Idaho	339,000	34,313	101.2
Missouri	1,379,000	86,007	62.4
Kentucky	970,000	59,540	61.4
Rhode Island	240,000	14,303	59.6
Montana	238,000	13,528	56.8
Nevada	376,000	21,060	56.0
Ohio	2,854,000	156,635	54.9
Michigan	2,525,000	136,989	54.3
North Carolina	1,756,000	95,144	54.2
Delaware	175,000	9,441	53.9
Oregon	783,000	41,769	53.3
Alaska	192,000	10,071	52.5
California	**8,677,000**	**449,177**	**51.8**
Florida	3,262,000	164,945	50.6
New Mexico	498,000	24,933	50.1
Kansas	690,000	33,928	49.2
South Dakota	208,000	10,156	48.8
Georgia	1,893,000	89,958	47.5
Connecticut	788,000	37,043	47.0
New York	4,511,000	210,997	46.8
Illinois	3,083,000	140,651	45.6
West Virginia	429,000	19,544	45.6
Colorado	970,000	43,919	45.3
North Dakota	172,000	7,753	45.1
Utah	672,000	29,112	43.3
Iowa	729,000	31,240	42.9
Arizona	1,139,000	48,722	42.8
South Carolina	952,000	40,461	42.5
Indiana	1,473,000	62,553	42.5
Washington	1,408,000	57,100	40.6
Nebraska	442,000	17,508	39.6
Oklahoma	880,000	34,846	39.6
Massachusetts	1,424,000	56,178	39.5
Alabama	1,080,000	40,164	37.2
Wyoming	138,000	5,080	36.8
Louisiana	1,235,000	44,901	36.4
Mississippi	756,000	27,123	35.9
Wisconsin	1,347,000	47,561	35.3
Virginia	1,603,000	56,331	35.1
New Jersey	1,931,000	65,954	34.2
New Hampshire	292,000	9,666	33.1
Texas	5,301,000	173,644	32.8
Maryland	1,263,000	40,934	32.4
Maine	306,000	8,902	29.1
Arkansas	640,000	18,429	28.8
Tennessee	1,297,000	34,714	26.8
Minnesota	1,241,000	26,483	21.3
Vermont	146,000	3,025	20.7
Hawaii	304,000	5,944	19.6
Pennsylvania	2,898,000	23,722	8.2
United States	67,905,000	2,922,101	43.0

SOURCE: U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect, Child Maltreatment 1994: Reports From the States to the National Center on Child Abuse and Neglect, Washington, DC: Government Printing Office, 1996.

TABLE C-3
CHILDREN WITH SUBSTANTIATED OR INDICATED REPORTS OF ABUSE AND NEGLECT, 1994
States in Descending Order of Children with Substantiated Reports per 1,000 Children in the Population

States	Children in the Population	Children Reported as Abused and Neglected	Children with Substantiated/ Indicated Reports of Abuse & Neglect	Children with Substantiated/ Indicated Reports per 1,000 Children in the Population
Alaska	192,000	10,071	6,774	35.3
Connecticut	788,000	37,043	27,618	35.0
Georgia	1,893,000	89,958	63,721	33.7
Washington	1,408,000	57,100	44,197	31.4
Idaho	339,000	34,313	9,461	27.9
Kentucky	970,000	59,540	25,940	26.7
Arizona	1,139,000	48,722	29,531	25.9
Florida	3,262,000	164,945	77,101	23.6
Ohio	2,854,000	156,635	61,806	21.7
Nevada	376,000	21,060	8,037	21.4
North Dakota	172,000	7,753	3,617	21.0
Alabama	1,080,000	40,164	21,591	20.0
California	**8,677,000**	**449,177**	**159,031**	**18.3**
Montana	238,000	13,528	4,194	17.6
Illinois	3,083,000	140,651	53,056	17.2
Indiana	1,473,000	62,553	25,343	17.2
North Carolina	1,756,000	95,144	30,013	17.1
Massachusetts	1,424,000	56,178	23,964	16.8
Maine	306,000	8,902	4,769	15.6
Utah	672,000	29,112	10,430	15.5
New Mexico	498,000	24,933	7,356	14.8
Delaware	175,000	9,441	2,542	14.5
Wisconsin	1,347,000	47,561	18,185	13.5
Rhode Island	240,000	14,303	3,207	13.4
Iowa	729,000	31,240	9,172	12.6
Okalahoma	880,000	34,846	10,891	12.4
Arkansas	640,000	18,429	7,915	12.4
Wyoming	138,000	5,080	1,702	12.3
South Carolina	952,000	40,461	11,628	12.2
New York	4,511,000	210,997	54,993	12.2
Louisiana	1,235,000	44,901	15,015	12.2
Missouri	1,379,000	86,007	15,842	11.5
Mississippi	756,000	27,123	7,982	10.6
Texas	5,301,000	173,644	55,266	10.4
Nebraska	442,000	17,508	4,514	10.2
Oregon	783,000	41,769	7,946	10.1
Tennessee	1,297,000	34,714	12,175	9.4
South Dakota	208,000	10,156	1,923	9.2
Michigan	2,525,000	136,989	21,951	8.7
Vermont	146,000	3,025	1,234	8.5
Minnesota	1,241,000	26,483	10,471	8.4
Hawaii	304,000	5,944	2,380	7.8
Virginia	1,603,000	56,331	10,264	6.4
Kansas	690,000	33,928	3,644	5.3
New Jersey	1,931,000	65,954	9,519	4.9
New Hampshire	292,000	9,666	1,043	3.6
Pennsylvania	2,898,000	23,722	7,038	2.4
Colorado	970,000	43,919	*	*
Maryland	1,263,000	40,934	*	*
West Virginia	429,000	19,544	*	*
United States	67,905,000	2,922,101	1,005,992	14.8

SOURCE: U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect, Child Maltreatment 1994: Reports From the States to the National Center on Child Abuse and Neglect, Washington, DC: Government Printing Office, 1996.

TABLE C-4
RELATIONSHIP OF OFFENDERS TO CHILDREN WHO WERE ABUSED AND NEGLECTED, 1994

Relationship	Number of Reports	Percent of Children
Parents	537,273	82.4%
Other Household Members	67,286	10.3%
Non-Caregivers	31,981	4.9%
Child Care Providers	8,922	1.4%
Foster Parents	4,179	0.6%
Facility Staff	2,400	0.4%
Total	652,041	100.0%

SOURCE: U.S. Dept. of Health and Human Services, National Center on Child Abuse and Neglect, Child Maltreatment 1994: Reports From the States to the National Center on Child Abuse and Neglect, Washington, D.C.: Government Printing Office, 1996.

TABLE C-5
CHILDREN IN OUT-OF-HOME CARE, 1994
Per 1,000 Children in the Population
States in Descending Order of Children in Out-of-Home Care per 1,000 Children in the Population

State	Children in the Population	Children in Out-of-Home Care, 1994	Children in Out-of-Home Care per 1,000 Children in the Population, 1994
Illinois	3,083,000	44,825	14.5
Rhode Island	240,000	3,249	13.5
New York	4,511,000	58,858	13.0
California	**8,677,000**	**94,784**	**10.9**
Massachusetts	1,424,000	13,572	9.5
Vermont	146,000	1,384	9.5
Georgia	1,893,000	17,275	9.1
Indiana	1,473,000	12,384	8.4
Minnesota	1,241,000	10,379	8.4
Alaska	192,000	1,541	8.0
Maine	306,000	2,236	7.3
Wyoming	138,000	1,001	7.3
Nebraska	442,000	3,144	7.1
North Carolina	1,756,000	12,189	6.9
Montana	238,000	1,631	6.9
New Hampshire	292,000	1,999	6.8
Pennsylvania	2,898,000	19,735	6.8
Oklahoma	880,000	5,872	6.7
Nevada	376,000	2,479	6.6
Missouri	1,379,000	9,048	6.6
Washington	1,408,000	9,193	6.5
Kansas	690,000	4,501	6.5
Hawaii	304,000	1,938	6.4
Colorado	970,000	5,957	6.1
Wisconsin	1,347,000	8,070	6.0
Oregon	783,000	4,676	6.0
Connecticut	788,000	4,648	5.9
West Virginia	429,000	2,483	5.8
Maryland	1,263,000	7,143	5.7
Ohio	2,854,000	15,922	5.6
North Dakota	172,000	931	5.4
Iowa	729,000	3,800	5.2
South Carolina	952,000	4,886	5.1
Tennessee	1,297,000	6,186	4.8
Louisiana	1,235,000	5,831	4.7
Delaware	175,000	812	4.6
Mississippi	756,000	3,425	4.5
New Mexico	498,000	2,156	4.3
Michigan	2,525,000	10,709	4.2
Virginia	1,603,000	6,629	4.1
New Jersey	1,931,000	7,771	4.0
Arizona	1,139,000	4,271	3.7
Arkansas	640,000	2,358	3.7
Kentucky	970,000	3,514	3.6
Alabama	1,080,000	3,814	3.5
Florida	3,262,000	9,233	2.8
Idaho	339,000	949	2.8
Utah	672,000	1,766	2.6
South Dakota	208,000	534	2.6
Texas	5,301,000	11,315	2.1
United States	67,020,000	461,691	6.9

SOURCE: American Public Welfare Association, VCIS, Child Substitute Care Flow Data for FY 94 , Washington, D.C.: American Public Welfare Association, 1996.

TABLE C-6

CHILDREN REMOVED FROM THEIR HOMES BY CHILDREN SERVICES AGENCIES, 1994

States in Descending Order of Children Removed per 1,000 Children Reported as Abused/Neglected

State	Children in the Population	Children Reported as Abused and Neglected	Children Removed	Children Removed per 1,000 Children in the Population	Children Removed per 1,000 Children Reported
Pennsylvania	2,898,000	23,722	3,867	1.3	163.0
Wisconsin	1,347,000	47,561	6,364	4.7	133.8
Connecticut	788,000	37,043	4,690	6.0	126.6
Indiana	1,473,000	62,553	6,036	4.1	96.5
Maine	306,000	8,902	818	2.7	91.9
Nebraska	442,000	17,508	1,547	3.5	88.4
Vermont	146,000	3,025	266	1.8	87.9
South Dakota	208,000	10,156	882	4.2	86.8
Oregon	783,000	41,769	3,353	4.3	80.3
Minnesota	1,241,000	26,483	2,085	1.7	78.7
Alaska	192,000	10,071	771	4.0	76.6
Georgia	1,893,000	89,958	6,772	3.6	75.3
Massachusetts	1,424,000	56,178	3,735	2.6	66.5
Illinois	3,083,000	140,651	9,099	3.0	64.7
Utah	672,000	29,112	1,763	2.6	60.6
Florida	3,262,000	164,945	9,731	3.0	59.0
South Carolina	952,000	40,461	2,195	2.3	54.2
California	**8,677,000**	**449,177**	**24,117**	**2.8**	**53.7**
Louisiana	1,235,000	44,901	2,325	1.9	51.8
Michigan	2,525,000	136,989	6,804	2.7	49.7
Kentucky	970,000	59,540	2,594	2.7	43.6
Missouri	1,379,000	86,007	3,493	2.5	40.6
Mississippi	756,000	27,123	1,069	1.4	39.4
Rhode Island	240,000	14,303	562	2.3	39.3
New York	4,511,000	210,997	7,989	1.8	37.9
Hawaii	304,000	5,944	224	0.7	37.7
Virginia	1,603,000	56,331	1,953	1.2	34.7
North Carolina	1,756,000	95,144	2,943	1.7	30.9
Texas	5,301,000	173,644	4,607	0.9	26.5
Iowa	729,000	31,240	560	0.8	17.9
New Hampshire	292,000	9,666	129	0.4	13.3
Idaho	339,000	34,313	416	1.2	12.1
Ohio	2,854,000	156,635	1,534	0.5	9.8
New Jersey	1,931,000	65,954	634	0.3	9.6
Alabama	1,080,000	40,164	190	0.2	4.7
Arkansas	640,000	18,429	*	*	*
Arizona	1,139,000	48,722	*	*	*
Colorado	970,000	43,919	*	*	*
Delaware	175,000	9,441	*	*	*
Kansas	690,000	33,928	*	*	*
Maryland	1,263,000	40,934	*	*	*
Montana	238,000	13,528	*	*	*
Nevada	376,000	21,060	*	*	*
New Mexico	498,000	24,933	*	*	*
North Dakota	172,000	7,753	*	*	*
Oklahoma	880,000	34,846	*	*	*
Tennessee	1,297,000	34,714	*	*	*
Washington	1,408,000	57,100	*	*	*
West Virginia	429,000	19,544	*	*	*
Wyoming	138,000	5,080	*	*	*
United States	67,905,000	2,922,101	126,117	1.9	43.2

* State data not available

SOURCE: U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect, Child Maltreatment 1994: Reports from the States to the National Center on Child Abuse and Neglect , Washington, D.C.: U.S. Government Printing Office, 1996.

TABLE C-7
FOSTER CARE CENSUS FOR CALIFORNIA AND FIVE OTHER STATES

	California	Illinois	Michigan	Missouri	New York	Texas	Total
1983	32,520	13,170	6,733	5,219	25,709	4,992	88,343
1984	36,540	13,145	7,249	5,129	25,480	4,996	92,539
1985	39,666	13,091	7,685	5,218	25,644	6,152	97,456
1986	43,599	13,363	7,913	5,224	27,472	6,058	103,629
1987	49,990	15,310	8,722	5,367	35,566	6,195	121,150
1988	57,150	16,982	9,206	5,589	46,318	6,704	141,949
1989	68,120	19,048	10,035	6,291	58,550	7,834	169,878
1990	70,826	21,484	10,794	6,757	62,787	8,560	181,208
1991	72,087	26,010	11,271	7,279	63,853	9,388	189,888
1992	74,875	30,801	11,154	7,781	62,000	10,211	196,822
1993	79,448	36,097	10,955	8,387	60,160	10,958	206,005
1994	85,367	43,711	11,126	8,873	57,474	11,781	218,332

TABLE C-8
PERCENTAGE OF CHILDREN LEAVING FOSTER CARE WITHIN SPECIFIED TIME PERIODS FOR CHILDREN ENTERING CARE IN 1990

Cumulative Percentage of Children Exiting Foster Care within the Specified Time Period

Year	California	Illinois	Michigan	Missouri	New York	Texas
1 Month	12.0	9.6	10.1	17.1	10.6	18.6
3 Months	22.7	19.0	23.9	36.6	19.8	30.4
6 Months	30.0	27.3	38.4	46.9	28.2	42.1
12 Months	42.9	37.8	50.8	59.5	38.4	57.3
18 Months	53.8	45.1	62.1	68.4	46.9	66.3
36 Months	70.7	58.9	83.0	81.9	64.1	81.5
>36 Months	78.3	67.8	91.0	89.8	76.0	89.4

SOURCE: George, R.M, Wulczyn, F.H., and Harder, A.W., A Report from the Multistate Foster Care Data Archive: Foster Care Dynamics 1983-1994 (Draft) , Chicago, IL: Chapin Hall Center for Children, 1996 (Unpublished).

TABLE C-9
FEDERAL FOSTER CARE EXPENDITURES UNDER TITLE IV-E, 1993
States in Descending Order of Per-Child Monthly Maintenance Payment

State	Average Monthly Number of Children in Title IV-E Foster Care	Title IV-E Maintenance Expenditures	Per-Child Title IV-E Monthly Maintenance Payment	Total Title IV-E Expenditures	Total Per-Child Title IV-E Expenditures
Indiana	2,541	$22,920,000	$751.67	$37,650,000	$1,234.75
Pennsylvania	15,020	125,880,000	698.40	180,460,000	1,001.22
Texas	4,920	38,480,000	651.76	72,180,000	1,222.56
New York	53,475	416,040,000	648.34	779,230,000	1,214.32
Maryland	3,073	23,820,000	645.95	44,600,000	1,209.46
Wyoming	97	750,000	644.33	1,050,000	902.06
Maine	1,000	7,200,000	600.00	9,440,000	786.67
Kentucky	1,797	12,730,000	590.34	34,060,000	1,579.48
New Hampshire	526	3,670,000	581.43	7,370,000	1,167.62
Ohio	6,546	44,820,000	570.58	91,980,000	1,170.94
Utah	454	3,030,000	556.17	5,960,000	1,093.98
Alaska	606	1,990,000	547.30	4,410,000	845.57
Illinois	11,349	73,880,000	542.49	117,500,000	862.78
North Dakota	402	2,490,000	516.17	5,410,000	1,121.48
Louisiana	2,784	16,560,000	495.69	28,560,000	854.89
Montana	557	3,260,000	487.73	4,580,000	685.22
South Dakota	225	1,270,000	470.37	2,570,000	951.85
Michigan	8,672	47,410,000	455.59	103,270,000	992.37
Kansas	1,371	7,440,000	452.22	19,370,000	1,177.36
Minnesota	3,607	18,710,000	432.26	33,000,000	762.41
Iowa	1,502	7,400,000	410.56	13,660,000	757.88
California	**48,526**	**232,180,000**	**398.72**	**478,060,000**	**820.97**
North Carolina	2,985	14,250,000	397.82	17,630,000	492.18
Rhode Island	673	3,190,000	395.00	8,080,000	1,000.50
Arizona	1,771	7,810,000	367.49	17,970,000	845.57
Nebraska	1,291	5,380,000	347.28	10,160,000	655.82
New Mexico	875	3,560,000	339.05	5,460,000	520.00
Oregon	1,882	7,270,000	321.91	14,080,000	623.45
Oklahoma	1,379	5,090,000	307.59	8,190,000	494.92
Vermont	1,145	4,180,000	304.22	6,650,000	483.99
Florida	4,191	14,630,000	290.90	45,880,000	912.27
Massachusetts	7,904	26,490,000	279.29	57,400,000	605.18
Connecticut	1,482	4,900,000	275.53	15,900,000	894.06
Washington	2,484	8,070,000	270.73	19,890,000	667.27
Arkansas	715	2,290,000	266.90	9,750,000	1,136.36
Idaho	225	720,000	266.67	2,150,000	796.30
Wisconsin	5,987	18,900,000	263.07	42,580,000	592.67
New Jersey	4,115	11,880,000	240.58	25,300,000	512.35
South Carolina	1,652	4,720,000	238.10	8,820,000	444.92
Missouri	4,555	12,710,000	232.53	29,070,000	531.83
Georgia	3,254	8,480,000	217.17	24,500,000	627.43
Nevada	621	1,610,000	216.05	2,880,000	386.47
Virginia	1,778	4,460,000	209.04	13,390,000	627.58
West Virginia	1,017	2,240,000	183.55	4,270,000	349.89
Hawaii	368	780,000	176.63	2,910,000	658.97
Colorado	2,521	4,900,000	161.97	20,270,000	670.04
Delaware	183	350,000	159.38	1,340,000	610.20
Alabama	810	1,510,000	155.35	4,680,000	481.48
Mississippi	868	1,560,000	149.77	4,090,000	392.67
Tennessee	6,533	9,140,000	116.59	15,770,000	201.16
United States	232,011	$1,303,000,000	$468.01	$2,513,430,000	$902.77

SOURCE: Curtis, P.A., Boyd, J.D., Liepold, M., and Petit, M., Child Abuse and Neglect: A Look at the States, Washington, D.C.: Child Welfare League of America, 1995.

TABLE C-10
ADOPTIONS OF CHILDREN UNDER PUBLIC AGENCY CARE, 1994-95
States in Descending Order of Children Adopted per 100 Children in Foster Care

State	Children in the Population [a]	Children Adopted in FY 1994/95 [b]	Children Adopted per 1,000 Children in the Population	Children in Foster Care FY 1994 [c]	Children Adopted per 100 Children in Foster Care
Michigan	2,525,000	1,860	0.7	10,382	17.9
Florida	3,262,000	1,683	0.5	9,568	17.6
Ohio	2,854,000	1,536	0.5	15,922	9.6
Virginia	1,603,000	579	0.4	6,233	9.3
New Jersey	1,931,000	663	0.3	7,673	8.6
Texas	5,301,000	871	0.2	10,880	8.0
New York	4,511,000	4,333	1.0	59,658	7.3
Illinois	3,083,000	1,640	0.5	33,815	4.8
Pennsylvania	2,898,000	916	0.3	18,976	4.8
North Carolina	1,756,000	387	0.2	11,024	3.51
California	**8,677,000**	**3,019**	**0.3**	**87,420**	**3.45**
Georgia	1,893,000	571	0.3	17,277	3.3

SOURCES:
[a] NCCAN, Child Maltreatment 1994: Reports from the States to the National Center on Child Abuse and Neglect, 1996.
[b] Department of Finance phone conversations with staff of the specified state's adoptions and children services agencies.
[c] American Public Welfare Association, Voluntary Cooperative Information Systems, Child Substitute Care Flow Data for FY 94 , 1996.

APPENDIX D
REVIEW OF RESEARCH ON FAMILY PRESERVATION PROGRAMS

In this appendix, we describe some of the research conducted on family preservation and family reunification programs. In some cases, our discussion is based on reviews conducted by other researchers who evaluated the original works. Where critical pieces of information, such as placement rates, were omitted from the works of the researchers conducting those reviews, we have supplied the information by turning to the original research. Like several other authors who have conducted critical reviews of family preservation, we have chosen to limit the discussion to studies involving the use of identified comparison groups because of known methodological problems associated with "before and after" comparisons and with comparisons involving groups about which critical characteristics are unknown.[153]

In a 1985 article, Theodore Stein reviewed seven research studies on family preservation (FP) and family reunification (FR) projects ranging in size from 90 to 525 cases.[154] He found that three of the projects reported statistically significant differences in placement rates favoring the families receiving FP/FR services, while four projects reported no significant differences between the families receiving FP/FR services and those not receiving the services. Stein cautioned readers against drawing definitive conclusions, pointing to the projects' methodological weaknesses, including use of worker judgment about children's risk of placement in foster care and the lack of information about the services provided to the treatment and control groups.

Five of the studies reviewed by Stein deserve mention because they reported information on the statistical significance of differences in placement rates found for the treatment and control groups. The first study is an evaluation of the New York State Preventive Services Demonstration Project conducted in the mid-1970's. For this project, 525 children were randomly assigned to a treatment group or a control group. The treatment group received

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[153] Blythe, B., Salley, M., and Jayarante, S., "A Review of Intensive Family Preservation Services Research," Social Work Research, 18(4), December 1994, pp. 213-224; Rossi, P. H., Evaluating Family Preservation Programs: A Report to the Edna McConnell Clark Foundation, New York: The Edna McConnell Clark Foundation, August 1991; Rossi, P. H., "Assessing Family Preservation Programs," Children and Youth Services Review, 14, 1992, pp. 77-97; and Wells, K. and Biegal, D.E., "Intensive Family Preservation Services Research: Current Status and Future Agenda," Social Work Research and Abstracts, 28(1), 1992, pp. 21-27.

[154] Stein, T.J., "Projects to Prevent Out-of-Home Placement," Children and Youth Services Review, 7, 1985, pp. 109-121.

intensive family preservation services for a period that averaged 19 months. The control group received less-intensive services. By the end of the treatment period, 7 percent of the treatment group and 18 percent of the control group had been placed in foster care, a statistically significant difference. At five years after treatment, 24 percent of the treatment group and 46 percent of the control group had been placed. Although this difference also is statistically significant, it is of questionable validity because fewer than half of the children could be located for the comparison. Nevertheless, the study is of particular interest because it is one of the few that attempted to track participants beyond 12 months from the end of treatment. The large increase in placement rates over time for both the families receiving services and the control families indicates the need for policy-makers to exercise caution in drawing conclusions about the long-term effectiveness of family preservation services from studies of short duration.

In another study reviewed by Stein, an evaluation of a mid-1970's New York project, 156 children who received intensive family preservation services were compared with 126 children (the control group) who received "standard child welfare services." By the end of the treatment period, 4 percent of the treatment group and 17 percent of the control group had been placed in foster care, a statistically significant difference. No follow-up data beyond the treatment period were reported by the evaluators.

The third study, involving a New Jersey project that also was conducted in the late 1970's, found placement rates of 24 percent for the 45 families included in the treatment group and 18 percent for the 45 families included in the control group. However, the difference was not statistically significant. No follow-up data were reported.

The fourth study, involving a Nebraska project that also was conducted in the late 1970's, found placement rates of 4 percent for the 80 families included in the treatment group and 11 percent for the 73 families included in the control group. However, the difference was not statistically significant. No follow-up data were reported.

The fifth study, involving a Hennepin County, Minnesota, project conducted in the late 1970's, found a higher number of placements (123) for the treatment group than for the control group (84). The project served 66 families and included a control group of 72 families, but data on the number of children included in either group was not provided and the statistical significance of the findings was not reported. Contrary to its findings on placements, the study found that children in the treatment group spent fewer days (199 days, on average) in placement than did the control children (208 days, on average). No follow-up data were reported.

As reported in a 1988 article by Frankel, a study involving 74 families in Ramsey County, Minnesota found that at three months after the services had ended, children from 33 percent

of the treatment group and 55 percent of the control group had been placed in foster care.[155] Furthermore, the children in the treatment group who were placed in foster care spent significantly less time in foster care than did the children from the control group who were placed in foster care. No follow-up data were reported.

Of interest concerning this study is that a group of families who were excluded from the study because placement of their children in foster care was imminent had a placement rate of 44 percent, which was less than that of the control group. This suggests that only a portion of "imminent-risk" cases end up in foster care. It also points to the unreliable nature of social workers' judgment about imminent risk of placement, a concern that is raised by several family preservation researchers and one that casts doubt on the validity of most of the research findings reported in this appendix. For example, Littell and Schuerman, in a comprehensive review of family preservation research conducted for the federal Department of Health and Human Services, note that in very few of the studies designed to serve children "at imminent risk of placement" did a large percentage of the control group experience placement. In their view, not only did this indicate the difficulty of identifying children at risk of placement, but it also meant that in the family preservation programs they reviewed, "services were generally not delivered to the target group of families at risk of placement."[156]

Littell and Schuerman reported on a study of Oregon's Social Learning Treatment Program, which included an evaluation of 24 children provided intensive family preservation services and 24 children (the control group) who were provided less intensive services. For the half of the children categorized as less difficult to treat, evaluators found placement rates of 8 percent for the treatment group and 38 percent for the control group. For the more difficult to treat children, the placement rates were 45 percent and 64 percent, respectively. Neither difference was statistically significant, and no follow-up data were reported.

In a 1991 article, Schwartz, AuClaire and Harris presented their findings of another Hennepin County, Minnesota, project, this one conducted during 1985 and 1986.[157] Half of the 116 families involved in the study received intensive FP services and the other half were placed in a control group and received only traditional child welfare agency services. The researchers found that 56 percent of the treatment group were placed in foster care during the treatment period, while 92 percent of the control group were placed in foster care. In addition, they found that the treatment group experienced less than half as many days in foster care than did the control group. However, the project was of very limited duration (16 months) and served primarily a limited population that may not be representative of the usual

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[155] Frankel, H., "Family-Centered, Home-Based Services in Child Protection: A Review of the Research," Social Service Review, March 1988, pp. 137-157.

[156] Littell, J.H., and Schuerman, J.R., A Synthesis of Research on Family Preservation and Family Reunification Programs, Rockville, MD: Westat, Inc., May 1995, p. 12.

[157] Schwartz, I.M., AuClaire, P., and Harris, L.J., "Family Preservation Services as an Alternative to the Out-of-Home Placement of Adolescents," in Wells, K. and Biegel, D.E. (eds.), Family Preservation Services: Research and Evaluation, Newbury Park, CA: Sage Publications, 1991, pp. 33-46.

child maltreatment cases, i.e., families with children with behavioral problems for which a voluntary, out-of-home placement already had been approved by the child welfare agency. In addition, there was no follow-up evaluation.

In 1991, Pecora, Fraser, and Haapala presented their findings concerning the effectiveness of a Homebuilders program that operated in Utah between August 1985 and August 1987.[158] In that program, 76 families were selected for treatment and 38 families were placed in a control group when they became candidates for FP services but could not be served because the FP program had reached capacity. The control group received more traditional child welfare or mental health services. The placement rate for the treatment group during the treatment period was 11 percent; the placement rate for the control group was not reported. At twelve months after treatment ended, the placement rates for the treatment and control groups were 44 percent and 85 percent, respectively. However, the control group's placement rate applies to only 27 of the 38 control families because 11 of the families were not tracked by the welfare department. Conceivably, some or all of those families may have avoided placement, making the placement rate for the control group lower than that found by the authors. Even so, the placement rate for the treatment group still would have been significantly lower than that of the control group.

As reported in Littell and Schuerman, in a 1988 study of 59 children served by the Families First Program (a Homebuilders program) in Davis, California, the researchers found that one year after intake 25 percent of the treatment group had been placed in foster care versus 53 percent of the comparison group (49 children), a statistically significant difference.[159] The control group was composed of children at imminent risk of placement who had been referred to the program but were not selected for services because of capacity limitations.

In the first large experimental study of family preservation, Yuan, McDonald, Wheeler, Struckman-Johnson, and Rivest evaluated California's AB 1562 In-home Care Demonstration Project, which operated in eight California counties between 1986 and 1989.[160] Data were collected on 709 of the 741 families served by the program, but the

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[158] Pecora, P.J., Fraser, M.W., and Haapala, D.A., "Intensive Home-Based Family Preservation Services: An Update from the FIT Project," Child Welfare, 71(2), March/April 1992, pp. 177-188. These findings also are described in Pecora, P.J., Fraser, M.W., and Haapala, D.A., "Client Outcomes and Issues for Program Design," in Wells, K. and Biegel, D.E. (eds.), Family Preservation Services: Research and Evaluation, Newbury Park, CA: Sage Publications, 1991, pp. 3-32. In both articles, Pecora, Fraser, and Haapala also presented their findings on another Homebuilders program operated in Washington during the same time period. In that program, which served 409 children, 7 percent of the children receiving FP services were placed in foster care during the treatment period and 30 percent of them had been placed at 12 months after treatment. However, there was no control group for that study. In addition, the findings are questionable in that 54 percent of the treatment group did not accept the services provided by the children services agency and 32 percent of the control group was not tracked. (Reported in Littell and Schuerman, op. cit., pp. 7-8.)

[159] Littell and Schuerman, op. cit., p. 6.

[160] Yuan, Y.T., McDonald, W.R., Wheeler, C.E., Struckman-Johnson, D., and Rivest, M., Evaluation of AB 1562 In-Home Care Demonstration Projects, Volumes I and II, Sacramento, CA: Walter R. MacDonald and Associates, 1990.

randomized experiment was conducted for a subsample of 304 families (152 each in the treatment and control groups) in five of the eight counties. The placement rates for children in the treatment and control groups were 18 percent and 17 percent, respectively, at eight months after referral. This difference was not statistically significant.

The study by Yuan, et al., also examined the effect of family preservation services on subsequent reports of abuse or neglect among the families receiving treatment. It found no statistically significant differences in the percentage of families in the treatment and control groups experiencing subsequent reports of abuse or neglect.

In the second large experimental study of family preservation services, involving 117 treatment families and 97 control families randomly assigned during New Jersey's Family Preservation Services project, placement rates of 6 percent for the treatment group and 17 percent for the control group were observed during the treatment period.[161] At 12 months after treatment, the placement rates were 43 percent and 57 percent, respectively, a difference that was statistically significant. However, Littell and Schuerman question the validity of the findings because 33 families (22 percent of the original sample size) who initially were assigned to the treatment group were later excluded from the evaluation because they did not meet the selection criteria, because the caretaker refused to participate in the program, or because the children were removed from their homes due to concerns about their safety.[162]

Despite the shortcomings noted by Littell and Schuerman, the New Jersey study is important because it is one of the few studies of family preservation that also evaluates the program's effect on family functioning. The evaluation found that although both treatment and control groups made gains on several scales of family functioning, there were no statistically significant differences between groups.

In the third large experimental study of family preservation services, involving 111 treatment families and 129 control families randomly assigned during the Los Angeles Family Support Project, 38 percent of the families in the treatment group and 24 percent of the families in the control group had children in placement at 12 months after the end of the treatment period.[163] Like the New Jersey study, this study also evaluated the program's effects on family functioning, and, like the New Jersey study, it found no significant differences in family functioning gains for the treatment and control groups.

The final large experimental study of family preservation services, involving 995 treatment families and 569 control families randomly assigned during the Illinois Family First

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[161] Feldman, L.H., "Evaluating the Impact of Intensive Family Preservation Services in New Jersey," in Wells, K. and Biegel, D.E. (eds.), Family Preservation Services: Research and Evaluation, Newbury Park, CA: Sage Publications, 1991, pp. 47-71.

[162] Littell and Schuerman, op. cit., p. 13.

[163] Meezan, W. and McCroskey, J., "Improving Functioning Through Family Preservation Services: Results of the Los Angeles Experiment," Family Preservation Journal, Winter 1996, pp. 9-29.

Experiment, has received much recent attention in the family preservation literature. In that project, conducted by researchers at the University of Chicago's Chapin Hall Center for Children, placement rates of 27 percent for the treatment group and 21 percent for the control group were observed. However, large variations in placement rates were observed for the six sites at which the experiment was conducted, and after adjusting for differences in client characteristics among sites, the differences in overall placement rates were found to be statistically insignificant. The evaluators concluded that the program served few families in which children would have been placed in the absence of treatment despite having an intended target population of children "at imminent risk of placement."[164]

Like the Los Angeles and New Jersey studies, the Illinois study also measured child and family functioning for a subsample of the families included in the experiment and found some statistically significant differences between groups. However, as reported in Littell and Schuerman, the gains for the treatment group were "modest and did not last over time."[165] The Illinois study also looked at differences in length of time in placement for children in the treatment and control groups who were eventually placed in foster care and differences in subsequent reports of abuse or neglect between the families composing the two groups. The evaluation found no statistically significant differences in either outcome.

[164] Littell and Schuerman, op. cit., p. 16.
[165] Ibid., p. 25.

APPENDIX E
FAMILY FUNCTIONING ITEMS TRACKED IN THE EVALUATION OF CALIFORNIA'S FAMILY PRESERVATION PROGRAM

Caregiver Interaction
Ability to Communicate
Supportive Relationship Between Caretakers
Partners' Attitudes Toward Each Other
Conjoint Problem Solving
Manner of Dealing with Conflicts and Stress
Balance of Power

Developmental stimulation
Provides Enriching/Learning Experiences
Ability and Time for Play
Deals with Sibling Interactions

Financial Conditions
Financial Management
Financial Problems (Welfare/Child Support)
Adequate Furniture
Financial Stress
Availability of Transportation

Parent-Child Interactions
Consistency of Discipline
Appropriateness of Discipline
Understands Child Development
Attitude About Children/Parental Role
Bonding Style to Children
Quality/Effectiveness of Communication with Child
Bonding to Caregiver
Use of Physical Discipline
Quality/Effectiveness of Communication Between Caregivers
Take Appropriate Authority
Child Cooperation with Parent
Schedule for Children

Living Conditions
Cleanliness/Orderliness Outside Home
Safety Inside Home
Cleanliness/Orderliness Inside Home
Appropriate Play Area Outside Home

Supports to Parents
Maintains Long-Term Adult Relationships
Available Child Care
Support from Friends, Neighbors and Community
Extended Family Support Choose Appropriate Substitute Caregivers
Provides Basic Medical/Physical Care

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APPENDIX F
REVIEW OF RESEARCH ON HOME VISITING

INTRODUCTION

We have relied to a great extent on two reviews of the literature, one conducted by Olds and Kitzman[166] and the other conducted by Wekerle and Wolfe.[167] Both reviews are limited to research using methodologically rigorous designs, i.e., those using randomly assigned treatment and control groups and those in which attempts were made to carefully control for differences among groups. We also review four studies that are not reviewed by either pairs of authors. Where appropriate, we have cited the original works. We have not reviewed research designed primarily to measure the effects of in-home services on educational gains because these programs are too narrow in scope to be considered comparable to home visiting programs being advocated by the Department of Social Services. Our summary is separated into categories that Olds and Kitzman used in their review to distinguish among studies with different primary objectives.

Prenatal Programs to Prevent Preterm Deliveries and Low Birth Weight

Olds and Kitzman reviewed seven studies of prenatal programs designed to reduce the incidence of preterm births and low birth weight among women deemed to be at risk for those birth outcomes. Although the risk categories varied from study to study, the women thought to be at risk of those outcomes are smokers; pregnant teenagers; low-weight women; young, single women; first-time mothers; women who had one or more previous preterm or low birth weight deliveries; women with previous miscarriages; women from low-income or otherwise socially disadvantaged homes; and women with low scores on a scaled instrument designed to measure family functioning.

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[166] Olds, D., and Kitzman, H., "Review of Research on Home Visiting for Pregnant Women and Parents of Young Children," The Future of Children, 3(3), 1993, pp. 53-92.

[167] Wekerle, C., and Wolfe, D., "Prevention of Child Physical Abuse and Neglect: Promising New Directions," Clinical Psychology Review, 13, 1993, pp. 501-540. We did not review studies reviewed by Wekerle and Wolfe that employed samples of less than 20 for either the treatment or control group or studies with only an educational emphasis. This eliminated six studies reviewed by Wekerle and Wolfe.

Olds and Kitzman found that none of the studies demonstrated that home visiting reduces preterm deliveries or low birth weights among the general population of women considered at risk for those outcomes. However, they note that few of the programs they reviewed employed strategies that might have been effective in altering adverse behaviors (smoking and substance abuse), e.g., combining teaching with assisting at-risk women in devising individualized strategies to maintain healthier habits. They speculated that home visiting may have been more effective had these strategies been employed. For example, in a study in which those strategies were employed, a study conducted by Olds and his colleagues in Elmira, New York, home visiting was found to have produced statistically significant reductions in preterm deliveries among women who smoked and reductions in low birth weight deliveries among pregnant teenagers. That study also found that home visiting had a statistically significant effect on improving health-related behaviors of pregnant women. For example, nurse-visited women smoked 25 percent fewer cigarettes by the end of their pregnancy than did the women in the control group despite the lack of differences in cigarette consumption among the two groups at the beginning of the study. However, in his presentation of the Elmira study, Olds noted that the sample for the Elmira study was atypical in that it contained primarily whites residing in a rural area. When a similar study (not included in the review by Olds and Kitzman) examined the effectiveness of home visiting for a group of at-risk black women residing in Memphis, Tennessee, no statistically significant differences between the treatment and control groups were observed in smoking frequency or low birth weight deliveries.[168]

Besides the Elmira and Memphis studies, only one study that used randomized trials assessed the impact of home visiting on health-related behaviors. That study showed no relationship between home visiting and pregnant women's reduction in smoking. Consequently, the research on the effectiveness of home visiting in improving health-related behavior can only be described as "mixed."

Programs to Remediate the Effects of Preterm Deliveries and Low Birth Weight

Olds and Kitzman reviewed four studies of home visiting programs designed to improve the cognitive development, motor development or health of preterm and low birth weight newborns. All four studies evaluated cognitive development, and they all found positive, statistically significant differences favoring the infants that were home-visited. However, Olds and Kitzman cautioned their readers that one of the studies was able to assess only 60 percent of the original sample at the 12 months and only 24 percent at 24 months, making that study's results somewhat questionable. Only one of the three studies that examined the infants' motor development found statistically significant differences between the treatment and control groups. Both studies that evaluated improvements in physical health (primarily

[168] Kitzman, H., Olds, D., Hanks, C., Henderson, C., Tatelbaum, R., Sidora, K., Luckey, D., Shaver, D., and Engelhardt, K., Influence of Prenatal Nurse Home Visitation on Women's Health-Related Behaviors, Preeclampsia, and Birth Outcomes among Low-Income Women with No Previous Live Births, forthcoming.

weight gain) showed positive, statistically significant differences in favor of the treatment group.

Programs for Families at Social or Economic Risk

Of the studies Olds and Kitzman reviewed, 19 were intended to measure the effectiveness of home visiting in improving the health, cognitive development, or general well-being of infants and other young children in low-income families, especially those in which other risk factors (e.g., pregnant teenagers, unmarried, first-time mothers, young mothers whose secondary education was incomplete, mothers with a history of mental illness) were present. In some cases, the intended outcomes related to improvements in parental caregiving, which presumably are correlated with the cognitive development, health and general well-being of the children of the caregivers. However, in other cases, specific measures of intellectual development and health of children were used in the evaluations.

Olds and Kitzman reported that the fifteen studies emphasizing cognitive and linguistic development of infants produced mixed results. Only six of the studies showed a statistically significant positive impact of home visiting on cognitive development, and only seven showed a statistically significant positive impact on parental caregiving. They noted, however, that the studies with samples of primarily the highest-risk families tended to show a positive, statistically significant relationship between home visiting and cognitive development and parental caregiving. Furthermore, low-income, unmarried teenagers appear to be helped most by the programs. However, they indicated that, in light of the available research, the findings needed to be replicated before conclusions could be drawn with any confidence.

Olds and Kitzman also noted that five of the six studies that showed a statistically significant impact employed professionals or highly trained staff, instead of paraprofessionals, suggesting that the type of staff makes a difference in the effectiveness of home visiting programs. They also noted that the programs that used paraprofessionals tended to be less comprehensive, i.e., focusing on only one or two forms of parent education and counseling, than those that used professionals. However, they suggested that additional research, involving comprehensive home visiting services, may be needed to determine the differential effects of using professionals and paraprofessionals.

Wekerle and Wolfe reviewed seven additional studies in which infants' cognitive and linguistic development are evaluated. In two of those studies, they reported no differences between the treatment and control groups. In the other five studies, they found differences favoring the treatment groups, but the statistical significance of the difference was not reported. They also reviewed nine studies that assessed the impact of home visiting on the caretakers' parenting abilities and found mixed results.

Some of the 15 studies of high-risk families reviewed by Olds and Kitzman show a positive relationship between maternal life-course development. For example, three of the four studies that evaluated the relationship between home visiting and the mother's educational achievement, participation in the work force, or family planning found positive and statistically significant relationships. Unfortunately, only one of the studies evaluated all three outcome measures and two studies evaluated only one outcome measure. Again, it appears that additional research is needed.

Wekerle and Wolfe reviewed two additional studies that examined the relationship between home visiting and employment or involvement in job training and the relationship between home visiting and educational attainment. The studies found that home visiting had a positive effect on these variables, although each study examined different factors and the statistical significance of the results were not reported.

Ten of the 19 studies of high-risk families that Olds and Kitzman reviewed assessed the effectiveness of home visiting in improving infant health and well-being. The outcome measures typically used for these evaluations were one or more of the following: the number of times the infants were seen by physicians for preventive purposes, the percentage of infants receiving immunizations, the number of infant emergency room visits, the number of illness visits to a physician, or the number of injuries and ingestions. Olds and Kitzman reported that seven of the ten studies demonstrated some benefits of home visiting on health by showing an increase in the use of health services. However, the studies that looked at emergency room or illness visits, or the number of injuries and ingestions, all of which are regarded as proxies for child maltreatment, showed mixed results. Positive, statistically significant results were obtained in only four of the ten studies. Moreover, the authors noted that local variations in health utilization stemming from differences in the availability of timely health care can affect the results. Consequently, they believe that a study's findings concerning the impact of home visiting on health should be assessed in the context of the study's overall findings; only where the findings concerning health impacts are consistent with the study's other findings should the health-related findings be regarded as credible. Consequently, the authors place most confidence in three studies: Olds' study conducted in Elmira, New York, in the late 1970's; a study of 95 infants in Washington, D.C. conducted in the early 1970's; and a study of 290 infants in Baltimore in the 1980's. All three studies showed a positive, statistically significant impact of home visiting on child health and well being.

Child Abuse and Neglect Findings

Six of the 19 studies reviewed by Olds and Kitzman examine the relationship between home visiting and child maltreatment. None of the six shows a statistically significant reduction in the rates of child maltreatment, as measured by state child welfare agency data on reports of abuse and neglect. And, as noted in the previous paragraph, the studies that used proxies for

child maltreatment (emergency room visits, etc.) showed mixed results.[169] Olds and Kitzman noted, however, that one study (the Elmira study) showed a statistically significant reduction in child maltreatment among women who were at greatest risk, as reflected by standard instruments designed to measure sociodemographic risk. In that study, there were verified cases of child maltreatment for only 4 percent of the children born to home-visited, low-income, unmarried teenagers, compared to 19 percent for the control group. However, the result seemed to be short-term in nature, as no statistically significant difference in maltreatment rates for the treatment and control groups was found at 24 months after the home visiting ended.

Wekerle and Wolfe, on the other hand, concluded from their review of the literature that home visiting has a beneficial impact on child maltreatment. They based their conclusion on their interpretation of the six studies reviewed by Olds and Kitzman and on four other studies that assessed the effects of home visiting on child maltreatment. Based on our review of the six studies reviewed by both Olds and Kitzman and by Wekerle and Wolfe, we believe that Wekerle and Wolfe have overstated the relationship between home visiting and child maltreatment that was found in the six studies. Furthermore, we question the reliability of three of the four additional studies reviewed by Wekerle and Wolfe. One of those studies simply measured the parent's risk of child maltreatment, not the actual reports of maltreatment, and another study used very small sample sizes (less than 20) for both the treatment and control groups. Consequently, we do not consider them to be reliable tests of the relationship between home visiting and child maltreatment. In the third study, involving 95 children (46 assigned to the treatment group and 49 to the control group), the evaluators found that at three years after treatment none of the treatment group had experienced reported cases of abuse or had a child placed in foster care. Similar data are not reported for the control group, and the statistical significance of any differences between the treatment group and the control group is not indicated. Furthermore, the control group was not randomly selected, and it appears that the evaluators made no effort to ensure that the treatment and control groups were comparable in areas related to risk of child maltreatment.

During our literature review, we also examined four other studies designed to measure the effect of home visiting on child maltreatment. The first is an evaluation of Project 12-Ways, a program implemented in Illinois in the early 1980's and designed to reduce the incidence of child abuse.[170] In that study, the evaluators found that 21 percent of the treatment group and

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[169] Some researchers maintain that if research involving short-term nature (six months or less) home visiting programs are discounted, there is a more compelling case for the effectiveness of home visiting in reducing child maltreatment. See McCurdy, K., Home Visiting, Chicago: National Committee to Prevent Child Abuse, December 1995, p. 19. However, mixed results on effectiveness are seen even when one ignore studies in which services are provided for only a short period. Although research seems to suggest that services are more effective if provided for a longer period, there appears to be no research that addresses the question of how long a period is needed before positive results are obtained. See Barth, R.P. and Berry, M., "Outcomes of Child Welfare Services under Permanency Planning," Social Service Review, March 1987, pp. 82-83.

[170] Lutzker, J., and Rice, J., "Project 12-Ways: Measuring Outcome of a Large In-Home Service for Treatment and Prevention of Child Abuse and Neglect," Child Abuse and Neglect, 8(4), 1984, pp. 519-524.

28 percent of the control group had substantiated instances of child maltreatment subsequent to the treatment period and that the difference was statistically significant. However, the study involved a comparison group, not a randomly assigned control group, and the authors did not control for potentially significant differences between the two groups. Consequently, the validity of the findings is questionable.

The second study is an evaluation of 187 families (110 in the treatment group and 77 in the control group) in which risk factors related to child maltreatment were present.[171] The treatment group was given prenatal and postpartum (for 12 months) home visiting services by nurses and social workers. The study found that more women in the treatment group (32 percent) reported that their children were placed in out-of-home care than was the case for women in the control group (19 percent). However, the difference was not statistically significant.

The third study was conducted by Olds and his colleagues and was designed to replicate Olds' Elmira study for a group of low-income, black women living in a predominantly urban area (Memphis, Tennessee). In that study, Olds found similar findings to those of his Elmira study: no statistically significant differences in reports of child maltreatment but statistically significant differences favoring the treatment group in infant visits to emergency rooms and in the number of injuries and ingestions.[172]

The fourth study is an evaluation of Hawaii's Healthy Start Program conducted by the National Committee to Prevent Child Abuse for the National Center on Child Abuse and Neglect.[173] The evaluation involved 304 families of newborns at risk of child maltreatment. The families were randomly assigned to the treatment group (147 families) or the control group (157 families) and were tracked for two years. During the study period, the treatment families were provided home visiting services, which included "mentoring" by the paraprofessional visitors; weekly parent education meetings; mental health group therapy services (for part of the treatment period); transportation to medical appointments; referrals to public health programs, such as Women, Infants and Children (WIC) programs, and other public programs for clothing, furniture, and food; referral to anger-management; and referral to substance-abuse counseling, where appropriate. The evaluation was designed to address weaknesses in previous evaluations, in particular the lack of random control groups, lack of information about the subjects' risk of child maltreatment when treatment began, small sample sizes, measurement of only short-term effects, and the sole reliance on rates of child maltreatment for measuring program outcomes. However, because the intake process was

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[171] Marcenko, M. and Spence, M., "Home Visitation Services for At-Risk Pregnant and Postpartum Women: A Randomized Trial," American Journal of Orthopsychiatry, 64(3), July 1994, pp. 468-478.

[172] Olds, D., Kitzman, H., Henderson, C., Hanks, C., Cole, R., Sidora, K., McConnochie, K., James, D., Engelhardt, K., and Barnard, K., Reducing Dysfunctional Parenting, Childhood Injuries, and Repeated Childbearing in Low-Income Families: Replication of a Randomized Trial of Nurse Home Visitation, forthcoming.

[173] Daro, D., Intensive Home Visitation: A Randomized Trial, Follow-up and Risk Assessment Study of Hawaii's Healthy Start Program, Final Report, Chicago: National Committee to Prevent Child Abuse, June 15, 1996.

slow, the evaluation period for the entire sample had to be shortened to 12 months from 18 months, and the 24-month follow-up evaluation involved too few families to allow meaningful data analysis.

The evaluation of Hawaii's Healthy Start Program found that home visiting produced statistically significant improvements in parental attitudes toward children, parent-child interaction patterns and the "type and quality" of child maltreatment. Both the treatment group and control group experienced reductions in their potential for physical abuse of their children, as measured by their scores on standardized tests, after 12 months of treatment. However, the mothers who were part of the treatment group experienced a 34 percent reduction in their abuse potential compared with a 10 percent reduction experienced by the control group. Furthermore, this difference was statistically significant even after between-group differences in maternal age, employment status, educational attainment and self-esteem were accounted for. Similarly, child maltreatment was confirmed in six instances (four percent) for the treatment group and 13 instances (eight percent) for the control group, a statistically significant difference. Equally important according to the evaluator was the less serious nature of the maltreatment (generally "imminent harm") for the treatment group than for the control group (which included "neglect" as well as "imminent harm"). The evaluation also concluded that there were no statistically significant differences between groups in children's gains in cognitive or behavioral functioning. Unfortunately, there was no follow-up beyond the 12-month point, so the long-term impact of treatment was not assessed.

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APPENDIX G
COUNTY FAMILY PRESERVATION PROGRAM
SUCCESS STANDARDS

Welfare and Institutions Code Section 16500.5(c)(6) The program in each county shall be deemed successful if it meets the following standards:

(A) Enables families to resolve their own problems, effectively utilize service systems, and advocate for their children in educational and social agencies.

(B) Enhancing family functioning by building on family strengths.

(C) At least 75 percent of the children receiving services remain in their own home for six months after termination of services.

(D) During the first year after services are terminated:

(i) At least 60 percent of the children receiving services remain at home one year after services are terminated.

(ii) The average length of stay in out-of-home care of children selected to receive services who have already been removed from their home and placed in out-of-home care is 50 percent less than the average length of stay in out-of-home care of children who do not receive program services.

(E) Two years after the termination of the family preservation services:

(i) The average length of out-of-home stay of children selected to receive services under this section who, at the time of selection, are in out-of-home care, is 50 percent less than the average length of stay in out-of-home care for children in out-of-home care who do not receive services pursuant to this section.

(ii) At least 60 percent of the children who were returned home pursuant to this section remain at home.

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APPENDIX H
OPTIONS FOR RECOVERY PILOT PROJECT SUCCESS STANDARDS

Welfare and Institutions Code Section 16525.28 (a) The project established pursuant to this chapter shall be deemed to be successful if, by the end of the first year of the demonstration project, 25 percent of children adjudicated dependents of the juvenile court who require placement outside their own homes and who are alcohol- or drug-exposed or HIV positive are placed in licensed foster family homes or with relative caretakers in which the foster parents or relatives were recruited and trained pursuant to this chapter to care for, and to provide specialized in-home health care to, a child who is alcohol- or drug-exposed or HIV positive.

(b) The project shall be deemed to be successful if, by the end of the demonstration project, 75 percent of the eligible children are placed in foster homes or with relative caretakers described in this chapter.

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APPENDIX I
AB 1741 YOUTH PILOT PROGRAM

Welfare and Institutions Code Section 18987 (a) Notwithstanding any other provision of law related to the funding and delivery of State programs and services specified in this section, designated counties, if they comply with the provisions of this chapter, shall be authorized to transfer, to the extent possible, into a county child and family services fund, for five-years, some or all funds for at least four of the following services for children and families:

(1) Adoption services.
(2) Child abuse prevention services.
(3) Child welfare services.
(4) Delinquency prevention services.
(5) Drug and alcohol services.
(6) Eligibility determination.
(7) Employment and training services.
(8) Foster care services.
(9) Health services.
(10) Juvenile facilities.
(11) Mental health services.
(12) Probation services.
(13) Housing.
(14) Youth development services.
(15) All other appropriately identified and targeted services for children and families.

Section 18987.45 The pilot program authorized by this chapter shall be deemed successful in a given county if, at a minimum, the outcomes from the services funded by the county child and family services fund show improvement over baseline performance.

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APPENDIX J
CALIFORNIA'S CHILD WELFARE WAIVER PROPOSAL OUTCOME MEASURES[174]

Extended Voluntary Component

- Decrease court costs.
- Increase the percentage of foster children achieving reunification with families within 12 months.
- Increase or maintain levels of child safety in the target populations.
- Decrease the prevalence of children in dependency status.
- Achieve high levels of client satisfaction.

Kinship Permanence Component

- Reduce court caseload and/or costs.
- Increase level of legal permanence for children in relative care.
- Reduce or maintain recidivism rate of target population so that it is not higher than that of the general foster care population.
- Reduce the number of children with relatives in long-term care caseload.
- Increase or maintain levels of child safety in the target populations.
- Achieve high levels of client satisfaction.

[174] Source: California Department of Social Services, California's Child Welfare Waiver Proposal, November 1, 1996.

Services Component

- Decrease the proportion of young children placed in group homes.
- Decrease the number of placement changes for individual children.
- Out-of-home care costs plus service costs will not exceed waiver proposal projected costs.
- Achieve high levels of client satisfaction.
- Increase or maintain levels of child safety in the target populations.

In addition, the following outcomes will be utilized with the target populations to which they can be linked:

- Increase the proportion of children in less restrictive, more family-like settings (e.g., otherwise removed, re-entry reduction, higher or lower level). Increase the number of children moved from non-relative placements.
- Decrease length of stay between entry into out-of-home placement and permanence (e.g., reduce re-entries, move laterally or to higher level, higher level to lower level).
- Decrease the length of stay in foster care (e.g., re-entry reduction, higher to lower level).
- Reduce recidivism rates for the target populations; subsequent child abuse reports; and re-entry to foster care and placement at a higher level of care.
- Reduce the number of children who moved from a less restrictive to a more restrictive placement.

APPENDIX K
STANDARD MONTHLY RATES FOR FOSTER CARE PROVIDERS AS OF JANUARY 1997

	Foster Family Homes	Foster Family Agencies	Group Homes	
Age of Child	Rate*	Rate	Level	Rate
0-4 Years	$ 345	$ 1,283	RCL 1	$ 1,183
5-8 Years	$ 375	$ 1,333	RCL 2	$ 1,478
9-11 Years	$ 400	$ 1,375	RCL 3	$ 1,773
12-14 Years	$ 444	$ 1,448	RCL 4	$ 2,067
15-18 Years	$ 484	$ 1,515	RCL 5	$ 2,360
			RCL 6	$ 2,656
			RCL 7	$ 2,950
			RCL 8	$ 3,245
			RCL 9	$ 3,539
			RCL 10	$ 3,834
			RCL 11	$ 4,127
			RCL 12	$ 4,423
			RCL 13	$ 4,720
			RCL 14	$ 5,013

Foster Family Agency Rate Formula

Treatment Rate

(Foster Family Home Rate {age based} + $175 Child Increment + Max. $250 Social Work Costs) x 2/3

- The monthly grant is split between the FFA and the certified home.
- The FFA certified home must receive the FFH basic rate plus the $175 Child Care Increment.
- The $250 augmentation is for social work activities for which the FFA is responsible.
- The FFA retains the additional 2/3 increase for administrative costs (e.g., foster parent recruitment & training.)

Non-treatment Rate (Foster Family Home Basic Rate (aged-based))

- The entire monthly grant is provided to the certified family home
- The FFA retains no portion of the monthly grant.

* Children placed in a licensed foster family home are eligible for a specialized care increment (SCI). Each county establishes its own rate for the SCI; however, in 1996 the average rate was $305.

DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, CA 95814

February 21, 1997

Mr. Bernard R. Kalscheuer
Assistant Program Budget Manager
Department of Finance
915 L Street
Sacramento, California 95814

Dear Mr. Kalscheuer:

Thank you for the opportunity to respond to the Performance Review, California's Child Welfare System. The California Department of Social Services has reviewed the report, and we substantially agree with your recommendations. There are only a few comments we want to make in this letter.

First, the structure, leadership, and management issues were not addressed in your review. These issues, I believe, are vital elements to any effective system and should be considered when analyzing a system.

Second, we generally agree with your recommendations on risk assessment, but believe that the need for risk assessment statewide is so urgent and such an important safety issue for children that we recommend the development of the system and the training modules occur concurrently with efforts to ensure proper implementation.

Third, while we still have questions about the numbers presented in the multi-state comparison of adoption rates, we will resolve these questions through the good practices survey of other states to be undertaken as part of the Governor's Adoption Initiative.

Finally, we are pleased that the report concurs with Department approaches to introducing home visiting. However, the discussion of home visiting- needs to be viewed in a larger context. As you very accurately pointed out in the report the problems of child abuse and neglect are complex and multi-faceted. The solutions will also be multi-faceted and complex. Singular solutions will not prevail and we do not believe in a "magic bullet." We do believe, however, in the need to provide assistance early to families in trouble, not only to prevent child abuse but because all of the emerging neurobiological research shows the critical developmental periods for children are the first few months and years of life. We believe it is important to study the experience of other states, knowing there is no single service answer, and to examine how positive outcomes were achieved by dedication to a range of prevention activities, all of which may have contributed to the overall results.

Lastly, there has been a 15-year follow-up study of the Elmira home visiting study. David Olds reports,

> *"The beneficial effects of file program on state-verified cases of child abuse and neglect, repeated child bearing, and welfare dependence in the Elmira sample have actually grown over time in the children's 4-15 year age range. It should be noted that the substantial reduction in rates of state-verified reports of child maltreatment in the 4-15 year age range overrode the biasing effects for nurse-visited children to be identified at lower thresholds of maltreatment,, because of the greater surveillance introduced as a result of the nurses' involvement with the family. Moreover, we also found long-term effects of the program on the mother's and children's self-reported arrests where the mothers were unmarried and low-income at registration during pregnancy. While these findings are concentrated on low-income unmarried mothers, this is the population at greatest risk for welfare dependence and dysfunctional caregiving. These findings have been reported at scientific conferences and will be submitted to JAMA within days."*

We regret that this information is so recent that it could not have been included in the review. There will be a report on Olds 15 year follow up study at The Western Regional Within Our Reach, Effective Home-Based Strategies Conference on April 1-2, 1997, at the Hyatt Regency here in Sacramento. We expect to evaluate emerging research and the methods of effective prevention.

Your report will be useful in continuing discussions regarding child protection, and it will also be useful to our efforts to improve child welfare services. We are particularly appreciative of the efforts of Walt Schaff, who covered the State, attended training, interviewed dozens of stakeholders from every perspective and reported these experiences in clear language.

Sincerely,

ELOISE ANDERSON
Director